63

UNITED NATIONS

A

General Assembly

Distr.
GENERAL

A/CONF.157/PC/61/Add.7
22 February 1993

Original: ENGLISH

WORLD CONFERENCE ON HUMAN RIGHTS
Preparatory Committee
Fourth session
Geneva, 19-30 April 1993
Item 5 of the provisional agenda

# STATUS OF PREPARATION OF PUBLICATIONS, STUDIES AND DOCUMENTS FOR THE WORLD CONFERENCE

## Addendum

## Contribution from the Economic and Social Commission for Asia and the Pacific

GE.1993-10987

Human Rights Related Concerns in the Asian and Pacific Region

A. Human Rights System in Asia and the Pacific.

B. The Right to Social Development.

1. The regional social situation.

2. Civil and political rights in the region.

3. Social Development Strategy for the ESCAP Region Towards the Year 2000 and Beyond.

C. Advancement of Women.

1. Major women's rights instruments.

2. The status of women in the region.

(a) Economic participation in the modern economy;

(b) De jure and de facto legal status of women;

(c) Women's human resources development and quality of life.

3. Overview of ESCAP activities.

D. Children's Rights.

E. Disabled Persons' Rights.

1. The regional disability situation.

2. Overview of ESCAP activities.

F. Concluding Remarks.

## HUMAN RIGHTS RELATED CONCERNS IN THE ASIAN AND PACIFIC REGION

The Asia-Pacific region is the world's largest and most populous. Six of the world's nine most populous states are in the region: China, India, Indonesia, Japan, Bangladesh and Pakistan. Its ethnic fragmentation, linguistic and religious diversity and immense contrasts in levels of economic and social development, and its variety of governments (from highly authoritarian military-dominated systems to relatively open, civilian controlled systems) set the region apart from other regions in the world. The region, also contain some of the world's most successful economies, i.e., that of Japan and newly industrializing economies (Hong Kong, the Republic of Korea, Singapore and Taiwan Province of China). While the region's overall economic performance is buoyant in recent years, there are still a number of countries showing slow economic and social development. Among these there are eleven of the world's least developed countries. Widespread economic and social deprivations in the region mean impoverishment and lack of empowerment of victimized groups. In view of these characteristics, marked contrasts exist among and within countries in awareness, practice and protection of human rights.

This report highlights broadly significant human rights related issues in the region. It provides an overview of the role ESCAP has played in addressing the major human rights related concerns. Firstly, human rights system in the ESCAP region is briefly discussed. Secondly, regional social situation is reviewed as realization of social and economic rights are widely considered as basic requirements for promotion and protection of other rights. As women comprise approximately half of the population in the region, an account of realization of human rights will be far from complete without a focus on the status of women in the region. The advancement of women is one of the key human rights issues of our times. Therefore, thirdly, the paper

reviews the disadvantaged position of women as participants in and beneficiaries of development. Fourthly, the status of children's rights in the context of child prostitution as an emerging issue in the region is also examined in the paper. Fifthly, the situation concerning the rights of disabled persons is presented. It must be pointed out that ESCAP does not consider human rights as within its mandate and therefore there is no human rights component in the activities of ESCAP. However, there are several programmes at ESCAP, under which activities having a direct bearing on realization of human rights are carried out.

## A. Human Rights System in Asia and the Pacific

The Universal Declaration of Human Rights (UDHR) adopted by the United Nations General Assembly in December 1988, lists a series of rights in 30 articles[1]. While the UDHR is the most important international document on human rights. A significant body of international human rights law has developed since the adoption of UDHR. Numerous international declarations (which are not legally binding), international conventions (which are legally binding on those states ratifying them, unless specific reservations are entered) and regional agreements bearing on human rights have been adopted since in more than 40 years the UDHR was adopted. Examples include the International Convention on the Elimination of All Forms of Racial Discrimination of 1965; the International Covenant on Economic Social and Cultural Rights of 1966; the Convention on the Elimination of All Forms of Discrimination Against Women of 1979; the Declaration on the Rights of Disabled Persons of 1975; Declaration on the Rights of Mentally-Retarded

---

[1] For the full text of the Universal Declaration of Human Rights see Ian Brownlie, ed., Basic Documents on Human Rights, second edition (Oxford: Clarendon Press, 1981), pp. 21-27.

Persons of 1971: Declaration on the Rights of Deaf-Blind Persons of 1979; and the Convention on the Rights of the Child of 1989.

In some regions such as Africa, Latin America and Europe regional conventions on human rights have been adopted. In Latin America and Europe, human rights courts are deciding cases and, in Africa, a regional human rights commission is functioning. However, in the Asian and Pacific region there are no regional or subregional conventions on human rights and no intergovernmental commissions or regional courts of human rights.

While intergovernmental human rights institutions and instruments have not evolved in the Asian and Pacific region, the focus on governmental activity alone does not convey a complete picture of human rights concerns in the region. Scholars, activists and non-governmental organizations in the Asian and Pacific region are active in human rights concerns.[2]

In 1982 the United Nations held a seminar in Colombo, Sri Lanka, to consider the advisability of establishing an Asian human rights commission.[3] Participants at the Seminar which included non-governmental observers did not recommend the establishment of such a commission. However, they identified many of the common human rights problems of the region, particularly unemployment, illiteracy, economic exploitation, discrimination against women and child labour. It was pointed out by the participants that human rights

---

[2] For information on major non-governmental human rights organizations in the region see Virginia A. Leary, "The Asian Region and the International Human Rights Movement", in Claude E. Welch, Jr., and Virginia A. Leary ed. Asian Perspectives on Human Rights (Boulder: Westview Press), 1990, pp. 19-25.

[3] Seminar on national, local and regional arrangements for the promotion and protection of human rights in the Asian region, organized by the United Nations Division of Human Rights, Programme of Advisory Services, Colombo, Sri Lanka, June 21-July 2, 1982, ST/HR/SER.A/12. Participants from the following countries attended the seminar: Afghanistan, Australia, Bangladesh, China, Cambodia, France, India, Maldives, Mongolia, Nepal, New Zealand, Pakistan, Republic of Korea, Sri Lanka, Thailand, Union of Soviet Socialist Republics, United Kingdom of Great Britain and Northern Ireland, United States of America, and Vietnam.

must be seen as an integral part of the struggle of social transformation. Rights to self-determination, to accelerated economic and social development, the rights to a just economic order, rights to education, to life, to a fair trial and to equality were mentioned as of fundamental importance in the region. However, realization of economic and social rights were considered as basic requirements for the effective protection of other rights.[4]

## B. The Right to Social Development

### 1. The regional social situation

The consistently high rates of economic growth in most of the developing countries in the ESCAP region in the past two decades stand in sharp contrast to the slow progress in social development. Many countries in the region continue to be characterized by widespread poverty, particularly absolute poverty; high rates of population increase; uncontrolled environmental degradation and natural resource depletion; inadequate social infrastructure, including the facilities necessary for universal access to potable water, essential sanitation, basic public health, elementary education, housing, transport and the like; and inadequate provision for basic human rights and political freedoms. These and related social development deficiencies throughout much of the region have resulted in social discontent. Several countries in the region have witnessed sporadic outbursts of civil unrest and repressing public policy responses.

Rather than narrowing during the past decade, the economic gap between

---

[4] While no intergovernmental human rights commissions yet exist in the ESCAP region, steps toward formation of a sub-regional commission for the Pacific island countries have been initiated by a non-governmental organization called LAWASIA, the Association of Lawyers for Asia and the Pacific with headquarters in Australia. See Claude E. Welch, Jr. and Virginia A. Leary ed., op. cit., pp. 18-19.

the region's rich and poor, as measured in terms of incomes, occupations, and assets such as land, business ownership and movable wealth, has widened. Social tension - between economic classes, regional minorities, racial, religious and linguistic groups, and others - continues to contribute to political instability in many countries in the region. Repeatedly, this tension has been expressed through collective refusal to abide by public rules and regulations, particularly through mass protests, work stoppages, and acts of organized violence. Poverty, high levels of unemployment and underemployment, major disparities in the distribution of income and wealth, inadequate access to basic social services, and a general sense of pessimism concerning the prospects for improvement in the situation have added to the high levels of dissension and civil strife that exist in various countries in the region.[5]

Freedom, security and peace are prerequisites for economic and social development. They constitute essential elements of well-being for both the individual and society at large. While the ESCAP region has achieved some progress with respect to each of these concerns in recent decades, considerable further advance is required to ensure that all the people of the Asian and Pacific region may be assured of popularly acceptable levels of freedom, security and peace.

## 2. Civil and political rights in the region

It must be noted that a number of countries in Asia and the Pacific have adopted popularly approved constitutions extending internationally accepted civil liberties and political freedoms to all citizens. Similarly, positive steps have been taken in most of those countries to extend civil and legal

---

[5] ESCAP, Towards a Social Development Strategy for the ESCAP Region (ST/ESCAP/1170), Bangkok, 1992, pp. 6-8.

protection to women, children and youth, disabled persons, the destitute and other disadvantaged and vulnerable sections of society. Increasingly, access to basic education, health care, housing and other generally accepted necessities of life are being viewed by the majority of the region's Governments as social rights to which all citizens are entitled.

Evidence shows that some progress has been made in the region in the past several decades in reducing the extent of armed conflict, martial law, state-condoned terrorism, press censorship and the like. Multiple political parties, including opposition parties, have been introduced in countries where they had previously been banned. In others, greater popular participation has emerged in the selection of civilian leaders at both local and national levels. In still others, the long-standing imposition of martial law has given way to constitutionally based parliamentary systems of representative government.[6]

In addition, in recent years many of the region's governments have made efforts to forge new alliances with people's organizations in order to take into account values and aspirations of certain sections of society. Such organizations include those representing labour, minority and sectional interests, as well as such specific social concerns as law and order, gender equity, social security, delivery of basic social services, and environmental protection.

While there has been some improvements in recent years, both through the courts and through the police, the distribution of justice remains inequitable throughout much of the region. Members of the political, military, business and other elite; owners of land and other forms of wealth; urban residents; the better educated; and men (rather than women) are among those who have

---

[6] Amnesty International, Amnesty International Report, 1988 (London: Amnesty International), 1989.

preferential access to protection of person and property within the civil order. Even where discriminatory treatment is specifically proscribed, the bureaucratic complexities that pervade processes of legal protection and redress impose often insurmountable barriers to access. Civil defense systems in many countries of the region are known to be riddled with corruption. Judicial and police irregularities have also contributed to a growing sense of political malaise among the poor.[7] Thus, despite some gains, large sections of society in the Asian and Pacific region continue to lack acceptable conditions of freedom, security and peace. Particularly reflective of that situation is the fact that, by and large, the region continues to lag in the adoption of internationally established standards on human rights.

## 3. Social Development Strategy for the ESCAP Region Towards the Year 2000 and Beyond

The ESCAP at its forty-fifth session in 1989 adopted resolution 45/1 of 5 April 1989 on a regional social development strategy towards the year 2000 and beyond. The Commission in that resolution noted with great concern the critical social situation in many countries of the region, most clearly characterized by the persistence of mass poverty and widespread deprivation among disadvantaged and vulnerable groups in society. It referred to the eradication of poverty, pursuit of distributive justice, and enhancement of popular participation as central issues to be addressed by all development efforts in the region.

In accordance with that resolution, ESCAP undertook a major project to formulate a regional social development strategy. The activities under the project, carried out in three phases, led to the formulation of the Strategy. The Fourth Asian and Pacific Ministerial Conference on Social Welfare and

---

[7] ESCAP, Towards a Social Development Strategy for the ESCAP Region, op. cit., pp. 12-16.

Social Development, held at Manila from 7 to 11 October 1991, adopted by acclamation the Manila Declaration on a Social Development Strategy for the ESCAP Region Towards the Year 2000 and Beyond. The Conference also considered and agreed upon a number of proposals for the effective implementation of the Strategy.

The basic objectives of the Strategy are the eradication of absolute poverty, the realization of distributive justice and the enhancement of popular participation. The Strategy assigns priority to the advancement of the region's disadvantaged and vulnerable social groups, including women, children, youth, disabled persons and the elderly.[8]

In the human rights context, the following three paragraphs in the Strategy are noteworthy:

> In virtually all countries of the ESCAP region, the issue of human rights as a critical aspect of distributive justice requires urgent attention. Universal basic education, including literacy, is one essential means to that end, as it can provide the necessary awareness, understanding, communication skills and self-confidence through which all citizens may pursue their human rights. Improved access by all people, especially members of disadvantaged and vulnerable social groups, to the formal justice system in their pursuit of remedies for grievances is a second essential means to that end. A third essential avenue is land reform, which can provide the region's landless poor with the means of achieving self-reliance as a first step to claiming their full rights in society.[9]

---

[8] ESCAP, Social Development Strategy for the ESCAP Region Towards the Year 2000 and Beyond (ST/ESCAP/1124), Bangkok, January 1992, para. 1-4, p.15.

[9] Ibid, para. 13, p. 17.

> The hopes and aspirations of ordinary citizens throughout much of the ESCAP region for an improved quality of life remain unfulfilled in many respects. In many countries of the region, those unfulfilled expectations include such basic needs as food, shelter, health care and education. In addition, the fundamental desire of the people of the region to live their lives in dignity, peace and freedom in many cases remain unfulfilled.[10]
>
> All social institutions can be structured to play a role in ensuring that social development takes fully into account the value and dignity of the human person and ensures the promotion of human rights. As emphasized in the Declaration on Social Progress and Development proclaimed by the General Assembly in 1969, that responsibility requires the immediate and final elimination of all forms of inequality and exploitation of individuals.[11]

The Strategy sets out national policy and planning measures as well as regional support measures which need to be implemented in order to achieve the aims and objectives of the Strategy.[12]

Since the adoption of the Strategy, ESCAP has undertaken several activities in order to assist the countries in the region in achieving the aims and objectives of the Strategy.

---

[10] Ibid, para. 26, p. 20.

[11] Ibid, para. 27, p. 20.

[12] Ibid, pp. 32-44.

## C. Advancement of Women

### 1. Major women's rights instruments

The Charter of the United Nations is the first international instrument to mention equal rights of men and women in specific terms. In its Preamble, the Charter proclaims the determination of the peoples of the United Nations "to reaffirm faith in fundamental human rights, in the dignity and worth of the human person, in the equal rights of men and women" and "to employ international machinery for the promotion of the economic and social advancement of all peoples". This basic principle is elaborated in the Universal Declaration of Human Rights, which proclaims that "all human beings are born free and equal in dignity and rights" (article 1), and that "everyone is entitled to all the rights and freedoms set forth (therein) without distinction of any kind", including distinction based on sex (article 2).[13]

The principle of equality of men and women and the prohibition of discrimination against women are at the heart of many United Nations instruments which deal with particular rights of women, such as the Convention on the Political Rights of Women, the Convention on the Nationality of Married Women, the Convention and the Recommendation on Consent to Marriage, Minimum Age for Marriage and Registration of Marriages; and, in so far as they concern the status of women, the Supplementary Convention on the Abolition of Slavery, the Slave Trade, and Institutions and Practices Similar to Slavery and the Convention for the Suppression of the Traffic in Persons and of the Exploitation of the Prostitution of Others. In addition, these principles inspired a number of instruments adopted by the International Labour Conference, including the Underground Work (Women) Convention, 1935 (No. 45);

---

[13] United Nations Action in the Field of Human Rights, 1988, (United Nations Sales Publications E.88.XIV.2), p. 116.

the Night Work (Women) Convention (revised), 1949 (No. 89); the Equal Remuneration Convention for Men and Women Workers for Work of Equal Value of 1951 (No. 100); the Discrimination (Employment and Occupation) Convention of 1958 (No. 111); and the Workers with Family Responsibilities Convention, 1981 (No. 156); as well as the Convention against Discrimination in Education, adopted by the General Conference of the United Nations Educational, Scientific and Cultural Organization in 1960.[14]

2. The Status of women in the region

Although for more than forty years competent organs of the United Nations have worked vigorously to improve the status of women in various fields and to eliminate discrimination against women, in the Asian and Pacific region, as in other regions, the status of women is far from equal to that of men. Women, by virtue of their gender, experience discrimination in all areas of life. The continuation of women's stereotyped reproductive and productive roles, justified primarily on physiological, social and cultural grounds, has subordinated them in the general as well as sectoral spheres of development. In recent years despite economic progress measured in growth rates, at least for the majority of developing countries in the region, economic progress for women has virtually stopped, and social progress has slowed.[15]

(a) Economic participation in the modern economy

The female participation rate in the modern economy is much lower than that of men in the countries of this region. Moreover, women have yet to be integrated into all occupations and sectors and to obtain conditions and

---

[14] Ibid, p. 116.

[15] 1989 World Survey on the Role of Women in Development (United Nations Publication, Sales No. E.89.IV.2), 1989, p.6.

content of work comparable to men's. In both the developed and developing countries of the region, women on average earn far less than men. Quite often, women are paid less for the same work done by men. A significant gender wage differential continues to persist in the region. Statistics show that in Japan, women in manufacturing earn 41 per cent of the average male wages and in the Republic of Korea 50 per cent. In Hong Kong and Singapore, the average female manufacturing wages were 57 to 70 per cent of those of male employees in 1990. This represented a decline over 1980. In Sri Lanka, the differential deteriorated by 10 percentage points in a period of four years, from 75.5 to 65.7 per cent.[16]

It must be noted that women are employed at the bottom rung of the career ladder. In most countries in the region, there is high gender segregation in the work force with women employed in the modern economy in mainly four occupational groups: professional workers, clerical workers, service workers and production workers. In the category of professional workers women generally provide low-paid yet vital services in the teaching and nursing professions. In almost all the countries of the region including the industrialized countries, a high percentage of women in the modern work force are clerical workers because they usually do not have the skills for manufacturing work and because of trade union barriers to their entry into trades and production work. In production work, women are recruited mainly for unskilled or semi-skilled jobs.[17]

Women are generally poorly represented in administrative and managerial positions. Women's participation in decision making is currently low

---

[16] Calculated from International Labour Office, Yearbook of Labour Statistics (Geneva, 1991), table 17A.

[17] ESCAP, Women's Economic Participation in Asia and the Pacific, (ST/ESCAP/510), 1987, pp. 13-34.

throughout the private as well as public sector industries. The main sources of employment for women in several countries are in the following industries: textiles and clothing, food processing, chemical producing and electronics industry. The data show that industries that employ women have acquired an image of being low-paying ones. The clothing industry is an example; it was found to be one of the lowest paid industry in manufacturing sector where there is high concentration of female workers.

Many countries in the region have sought to speed industrialization through establishing Export Processing Zones (EPZ). Up to 90 per cent of the workers in many factories in EPZs such as textiles and electronics are female. Strict labour regulations keep them from unionization or other protection of their economic rights, personal health and safety, and basic dignity.[13]

In addition, women account for a disproportionate share of unemployment in most countries and have more limited access than men to jobs generally, especially at the higher occupational levels and have greater difficulty in securing adequate technical training or even information on finding and applying for available jobs.

(b) De jure and de facto legal status of women

Women's legal status in the countries of this region is not equal to that of men as discriminatory legislative provisions in the social, economic and political spheres continue to exist including provisions in the civil, penal and commercial codes and certain administrative rules and regulations. Within the region, gender inequality remains embedded in legislation on marriage and the family legislation that defines household obligations and the intra-household distribution of authority. Inequality also persists in

---

[13] 1989 World Survey on the Role of Women in Development, op. cit., pp. 171-183.

matters pertaining to, among other things, nationality, inheritance, land tenure, ownership and control of property, agricultural cooperatives, and access to credit. In some countries, although progress has been made to ensure the gender neutrality of legislation, measures are lacking with respect to their effective implementation and enforcement. A gap persists between the legal declarations on the rights of women and the full realization of these rights in daily life, owing to the entrenched opposition of the male-oriented society, weakness in the law and customary discriminatory practices. Moreover, the fact that the majority of women neither are aware of their legal rights nor have access to their legal entitlements perpetuates the status quo. The lack of information on women's rights by women as well as men and of women's recourse to justice has hampered the achievement of women's equal status in society throughout the region.[19]

(c) Women's human resources development and quality of life

Gender disparity in human resources development is evident in the countries of the Asian and Pacific region. Women suffer from lower level of human resources development compared to men as reflected in terms of illiteracy and low level of education, malnutrition, poverty, lack of adequate food and safe drinking water, inadequate shelter, high birth and infant mortality rates, and relatively poor health.

The economic slow-down in last several years, when coupled with continued growth of population in many developing countries of the region, has meant that what economic growth has occurred in aggregate has not been translated into improvement in per capita terms.

---

[19] ESCAP, selected issues in social development: Legal literacy among women in Asia and the Pacific (E/ESCAP/PSD(2)/5, Committee on Population and Social Development, second session, 19-23 November 1990, Bangkok.

Evidence shows that the adoption of national structural adjustment policies designed to redress economic ills have adversely affected the status and role of women. The adjustment policies often lead to a decline in per capita real income and increased poverty. It is estimated that the poorer groups of society tend to bear a disproportionate share of the burden of adjustment.[20] Because of the factors derived from pre-existing inequality between men and women, or male and female children, in most societies, women are over represented among the poor. Women have been also adversely affected by reduced per capita public expenditure on health, education and other social services regressing the efforts in achieving gender equality in these areas.

Increase in female-headed households in the region has been particularly pronounced due to difficult economic and social conditions, male migration and female participation in the work force. Female-headed households tend to be among the poorest in all countries which has grave implications for the present well being and future advancement of the women involved and their dependants.

## 3. Overview of ESCAP activities

ESCAP activities under the women in development programme involve research, training, the development of innovative approaches and pilot projects, information dissemination, the provision of advisory services, and the organization of meetings. The regional programmes for women give priority emphasis to development as an instrument towards realizing the goals of equality and peace.

ESCAP research activities on women have focused on two major needs: (i) Studies to provide a baseline description of the diverse status of women in

---

[20] G. Cornia, R. Jolly and F. Steward, eds. Adjustment with a Human Face: Protecting the Vulnerable and Promoting Growth, vol. 1 (Oxford, Clarendon Press, 1986).

the region in order to identify the roots of their disadvantaged positions in need of analyses; this is a focus that is maintained to monitor changes in their status through time; and (ii) Studies to assess the impact on women and their roles in their countries' development, modernization, and industrialization, especially in situations where women predominate and/or are disadvantaged. These studies have made people aware of women's disadvantaged status, provided policy analyses and guidelines on how to improve women's participation in development, and identified problems in research and measurement methodologies.

Training has also been used as a tool for confidence-building and making people aware of women's potential and development. The training activities for women undertaken by ESCAP have been directed at policy and planning, operational and grass-roots levels. Other courses dealing with management and business, development planning, income-generation and project administration, and also provided testing of new techniques and methodologies in the preparation of training manuals.

The developing of innovative activities especially for disadvantaged women have included income generation, development of appropriate technology, provision of credit and loan funds and upgrading and expanding of basic services such as water and power.

ESCAP has contributed to the promotion of women-related information exchange through its triannual Social Development Newsletter and its publication of global and regional developments and research findings. In response to numerous requests from members and associate members of ESCAP for an improved system of information on women in Asia and the Pacific, ESCAP has initiated a long-term project to develop a regional women's information network for Asia and the Pacific (WINAP). The objectives of the project are to gather, analyse and disseminate views, ideas and statistics related to

women in development in order to provide a channel for promoting cooperative activities among women in asia and the Pacific and an effective means of monitoring the advancement of women's status in the region in accordance with the provisions of the Convention on the Elimination of All Forms of Discrimination Against Women.

Major activities of WINAP consist of the following: (i) Development of training programmes on the management of women's information centres and technical processing of information; (ii) Improving statistics and indicators on women; (iii) Technical support and advisory services to strengthen national mechanisms on the information networks for women; (iv) Strengthening the WINAP regional focal point at ESCAP through organization and maintenance of appropriate computer facilities and development of women-related information databases; and (v) Publishing semi-annually WINAP Newsletter and other information related materials.

Considering that the region is highly diversified, many of the regional programmes based on geographical, cultural and developmental commonalities have been matched with consultancy services for the specific needs of individual countries. Advisory services have been provided by ESCAP upon request by Governments in the region.

ESCAP as a regional forum has facilitated exchanges of views and information on both policies and practical experiences in the area of women in development. There have been many instances of valuable region-wide meetings on women held under ESCAP auspices which have made important contributions to regional and global consultations.

## D. Children's Rights

Over the years, there has been a growing concern in the Asian and

Pacific region over exploitation and abuse of children including sexual abuse. In particular, there has been a phenomenal growth and internationalization of child prostitution, including both boys and girls in the region. Those trends in child prostitution have been closely associated with growth in adult prostitution, an increase in the absolute number of the poor, disparities in distribution of income and welfare among social groups and between men and women, rapid urbanization, high unemployment, migration from rural to urban areas as well as from developing to developed countries, and promotion of the tourist industry.

While a number of networks mainly at non-governmental level have emerged at national and regional levels to curb child prostitution and trafficking of young women, there is a serious lack of practical and viable economic measures and awareness-raising programmes to pre-empt entry of children into prostitution. Preventive measures taken by countries in the region are mainly in the form of periodic raids and saving child prostitutes from brothels. Developmental and rehabilitative measures relating to child prostitution are lacking in the region.

Recognizing prostitution as a crucial area of social concern in the region, ESCAP has carried out a number of activities to curb prostitution since 1985. In August 1991, ESCAP convened the Workshop on the Promotion of Community Awareness for the Prevention of Prostitution in the ESCAP Region at Lampang, Thailand. The main objectives of the Workshop were to provide a forum for the exchange of information and experience related to the prevention of prostitution, including child prostitution, and to consider strategies for promoting community awareness to prevent sexual exploitation and the trafficking of young people and children in countries of the ESCAP region. Representatives of government agencies and non-governmental organizations from a number of ESCAP member countries and various international organizations

concerned with the issue participated in the Workshop.

The Workshop formulated recommendations on national, regional and international level initiatives to prevent child prostitution as well as guidelines to promote community awareness for the prevention of child prostitution. It was recommended that all the countries in the ESCAP region should become party to the Convention on the Rights of the Child, adopted by the General Assembly in 1989. The Convention urges States parties to take all appropriate legislative, administrative, social and educational measures to protect children from all forms of physical or mental violence, injury or abuse, maltreatment or exploitation, including sexual abuse. The Convention defines children as those persons who are under 18 years of age. Moreover, the Workshop emphasized the need to take measures in accordance with the Plan of Action for implementing the World Declaration on the Survival, Protection and Development of Children in the 1990s, adopted at the World Summit for Children held in New York in September 1990 and later endorsed by the General Assembly at its forty-fifth session in November 1990. The Plan of Action calls for national and international efforts to play special attention and render protection and assistance to child workers and young people trapped in the bondage of prostitution, sexual abuse and other forms of exploitation.

The Workshop agreed on the following national level recommendations: (i) A mix of developmental, preventive and rehabilitative measures should be taken to curb child prostitution; (ii) Governments should create more income-earning opportunities for poor and marginalized groups of people, to prevent parents from victimising their children into prostitution as a survival strategy; (iii) Legislative measures should be strengthened to detect and punish middlemen, agents, brothel owners, dishonest policemen and other officials involved in child prostitution; (iv) Local initiatives and action directed towards the prevention of child and juvenile prostitution should be

encouraged.

It was emphasized at the Workshop that due to growing internationalization of juvenile and child prostitution, regional and international collaboration was required to deal with the problem. Particular mention was made of a need to promote cooperation among the countries in the region and between the countries in the region and in the developed countries outside the region to develop laws, regulations and policies to curb trafficking in and prostitution of children.

## E. Disabled Persons' Rights

### 1. The regional disability situation

According to United Nations estimates, 1 out of 10 persons is born with or acquires during his or her lifetime some physical, sensory or mental disability. This means that the Asian and Pacific region, with its population of over 2,900 million, has by far the largest number of the world's disabled persons, perhaps as many as 300 million.

The widespread poverty in the ESCAP region, closely associated with the underdeveloped condition of many of the region's economies, is itself a major cause of the high incidence of disability. Poverty is evident in low levels of nutrition, community health and general standards of cleanliness and sanitation. It is also closely associated with low levels of education and literacy, which restrict people's access to knowledge and information that would prevent disabling conditions.

In the more rapidly developing countries of the region, disability appears to be rising among two vulnerable groups. Increasing numbers of young people, who are more prone to risk-taking behaviour than people in other age groups, are becoming disabled through traffic and other accidents associated

with an active life-style, as the opportunities for such a life-style increase. At the same time, with increased longevity in many societies of the region, a growing percentage of their disabled people are of advanced age, since disability strikes elderly persons at a relatively high rate.

Disability in the developing countries of the Asian and Pacific region is frequently associated with occupational accidents in the industrial and agricultural sectors under the influence of rapid technological change. Inadequate safety measures, lack of proper training in the use of machinery and hazardous substances, poor public education on the prevention of disability and inadequate responses to offset disability when accidents happen account for a high incidence of disability in many of those countries.

The rapidly spreading problem of drug abuse in the region, which is in part a manifestation of the inability of individuals to adapt to rapid social and economic change, can also lead to disability. In a similar vein, many cases of mental illness have been precipitated by the breakdown of individual coping strategies as traditional social and economic support systems disintegrate.

In those parts of the region marked by armed conflict or civil unrest, large numbers of the survivors suffer disabilities of one sort or another. Violence, particularly where perpetrated through the use of modern weapons of war, has caused widespread life-long disability, psychological as well as physical, not only among the immediate survivors but also in their children, in various war-torn countries in the ESCAP region in recent years.[2]

Global and regional forums have made repeated calls for urgent action, with emphasis on the promotion of the full equality and participation of

---

[2] ESCAP, selected issues in social development: A regional support services network for disabled persons, E/ESCAP/PSD(2)/7, Committee on Population and Social Development, second session, 19-23 November 1990, Bangkok, pp. 1-2.

disabled persons in society. Despite the interest generated during the International Year of Disabled Persons (1981) and the early years of the United Nations Decade of Disabled Persons, 1983-1992, there is still, in most developing countries of the ESCAP region, relatively little understanding of and action on disability issues.

The equalization of opportunities, as defined in the World Programme of Action concerning Disabled Persons, is the process through which the general system of society, including housing and transportation, social and health services, educational and work opportunities, and cultural and social life, is made accessible to all.[22]

Intrinsic to the concept of equalization of opportunities is the need to provide the means for enabling disabled persons to participate in social, economic and political life on an equal basis with non-disabled persons. The enabling process that this entails necessitates change on the part of the non-disabled members of society to bring about significant improvement in the daily lives of disabled persons. Ultimately, that enabling process has to ensure that disabled persons enjoy the same degree of freedom and choice as non-disabled persons in social and occupational mobility and individual expression.

Rehabilitation, skills development, social integration and the building of barrier-free environments are the essential components of that enabling process for disabled persons to take charge of their own lives as agents of their self-empowerment.[23]

Although equalization of opportunities is a major goal of the World

---

[22] United Nations, World Programme of Action concerning Disabled Persons (New York, 1983), chap. I, sect. C., Definitions, para. 12, p. 3.

[23] See "ESCAP programmes on equalization of opportunities through community-based approaches" in Report of the Eighth Asia-Pacific Leadership Training Seminar: From Care to Self-help, Suva, 25-29 June 1990, (Asia-Pacific Regional Council, Disabled Peoples' International, in press), p. 7.

Programme, the concept is little known among the numerous government agencies and non-governmental organizations whose action is required for operationalization of the concept. The tendency in developing countries in the ESCAP region is for disability issues to be accorded low priority and to be dealt with in a single ministry, usually that concerned with social welfare. The result is that disabled persons are either institutionalized or have limited access to human resources development programmes.

## 2. Overview of ESCAP activities[24]

The proclamation of the United Nations Decade of Disabled Persons (1983-1992) stimulated increased concern for disability issues at both the regional and national levels in the Asian and Pacific region. Experience in the region indicated a pressing need for support to national disability policy and programme endeavours, particularly to enable people with disabilities to participate in national economic and social development. In response to that increased concern, ESCAP endorsed at its forty-first session in 1985 a new work programme element on the integration of disabled persons in development.

Initially, ESCAP activities relating to disability issues were designed to assist the less developed countries of the region in designing and implementing prevention and rehabilitation policies and programmes. However, the concluding years of the United Nations Decade of Disabled Persons saw growing recognition in the region that, of the three goals of the World Programme of Action concerning Disabled Persons (i.e., prevention, rehabilitation and equalization of opportunities for people with disabilities), the equalization goal was the most neglected. It was

---

[24] Based on ESCAP, Achievements of the United Nations Decade of Disabled Persons, 1993-2002, in the Asian and Pacific region: ESCAP Activities Pertaining to the United Nations Decade of Disabled Persons (1983-1992) (SD/DDP/2), Meeting to Launch the Asian and Pacific Decade of Disabled Persons, 1993-2002, 1-5 December 1992, Beijing.

recognized that this was an issue that ESCAP could play a particularly valuable role in helping to address.

Thus, at the urging of the Commission and its Legislative Committee on Social Development, the focus of ESCAP activities has evolved to emphasize the full participation and equality of citizens with disabilities. As the majority of disabled people in the region are handicapped by economic and social deprivation, this policy focus is also in keeping with the new thematic thrust of the Commission on poverty alleviation through economic growth and social development.

Disability issues have been discussed in several intergovernmental meetings including the Fourth Asian and Pacific Ministerial Conference on Social Welfare and Social Development convened in 1991. To facilitate Government consideration at those meetings of critical issues that emerged during the United Nations Decade, the secretariat prepared policy documents that included suggestions on action that could be pursued in the region towards the implementation of the World Programme of Action concerning Disabled Persons. Furthermore, to promote fulfilment of the goals of the World Programme of Action, the ESCAP secretariat organized several regional meetings and conducted training activities on issues such as the following: local human resources and technology development for disability-related services in poverty areas; planning and organization of disability prevention and rehabilitation services; development of national training programmes concerning disability; review and appraisal of the region's progress on achievement of the goals of the United Nations Decade of Disabled Persons; planning and development of community-based rehabilitation programmes; equalization of opportunities through community-based services; establishment and strengthening of self-help organizations of disabled persons; and community-based support services for disabled persons.

Further to the priority given to the concerns of disabled persons in the regional Social Development Strategy, ESCAP at its forty-eighth session in April 1992 adopted a resolution 48/3 on an Asian and Pacific Decade of Disabled Persons, 1993-2002. In adopting the resolution, the Governments of the region expressed their collective commitment to the full participation and equality of people with disabilities.

The Asian and Pacific Decade of Disabled Persons provides an opportunity for ESCAP region to consolidate the efforts initiated during the preceding United Nations Decade through a new emphasis on regional cooperation in support of progress at the national level. In particular, it provides a context for the strengthening of technical cooperation among developing countries, as well as between the region's developing and developed countries, in the resolution of key issues that affect the lives of people with disabilities.

A Meeting to Launch the Asian and Pacific Decade of Disabled Persons, 1993-2002 will be held from 1-5 December 1992 at Beijing. The Meeting will review and appraise the progress made in the region during the United Nations Decade of Disabled Persons, 1983-1992, towards fulfilment of the goals of the World Programme of Action concerning Disabled Persons: prevention of disability, rehabilitation of disabled persons and equalization of opportunities for people with disabilities. Based on that review and appraisal, the Meeting is expected to devise an agenda for action to be pursued in the implementation of Commission resolution 48/3: Asian and Pacific Decade of Disabled Persons, 1993-2002. The agenda for action is expected to contain policy categories related to areas of concern of direct relevance to the development of policies in support of the full participation and equality of people with disabilities in Asia and the Pacific including the following: national coordination; legislation; information; public awareness;

accessibility and communication; education; training and employment; prevention of disabilities; rehabilitation services; technical aids; self-help organizations; and regional cooperation.

## F. Concluding Remarks

It appears from the above analysis of major human rights related issues in the region that while there are a number of international and regional pronouncements on human rights related concerns, enforcement remains uncertain. The international community and many national governments lack the resolve and resources to rectify violations of human rights and other rights in most parts of this region.

As the Social Development Strategy encompasses the major areas of overall developmental concerns as well as concerns of vulnerable and disadvantaged groups of persons, ESCAP will endeavour to provide assistance to countries in the region in implementing the Strategy. With the realization of the aims and objectives of the Strategy in the countries of the region, "social justice" as a hallmark for human rights may prevail. ESCAP will also continue to play an important role in improving the participation of vulnerable and disadvantaged groups of persons, including women, in development and in ensuring equality in the realization of economic and social rights.

Moreover, the Commission has adopted a thematic approach for its programmes. Three major themes identified by the Commission for its work are: (i) regional economic cooperation; (ii) environment and sustainable development; and (iii) poverty alleviation through economic growth and social development. While the activities to be carried out under all the three themes will have a bearing on promotion and realization of human rights in the

region, the subprogramme on poverty alleviation through economic growth and social development with its focus on the ways and means of alleviating economic and social deprivation and promoting equity, will have a significant impact on promoting respect for human rights in the region.

64

UNITED
NATIONS

A

General Assembly

Distr.
GENERAL

A/CONF.157/PC/61/Add.8
29 March 1993

Original: ENGLISH

WORLD CONFERENCE ON HUMAN RIGHTS
Preparatory Committee
Fourth session
Geneva, 19-30 April 1993
Item 5 of the provisional agenda

# STATUS OF PREPARATION OF PUBLICATIONS, STUDIES AND DOCUMENTS FOR THE WORLD CONFERENCE

## Addendum

## Contribution from the World Health Organization

1. The attention of the Preparatory Committee is drawn to the attached contribution submitted by the World Health Organization entitled "Health as a fundamental human right and as a worldwide social goal". In part one of the document, the World Health Organization gives an account of its perspective on the implementation of the international covenants on human rights; in part two, WHO illustrates, through a series of examples of activities carried out by various WHO technical programmes, the principles discussed in part one; these topical papers cover the following areas:

1. The rights of patients;

2. The rights of the mentally ill, and the improvement of mental health care;

3. The rights of the child;

4. The rights of the elderly;

5. The rights of the disabled;

6. Human rights aspects of HIV/AIDS;

7. The rights of vulnerable groups and indigenous peoples;

8. The health status of least developed countries;

9. The role of health legislation;

10. Humanitarian emergency health assistance and rights of displaced populations; and

11. Equity in health care.

2. In addition, the World Health Organization has submitted, for information, three documents* related to human rights issues: (a) the final report of the WHO/FAO International Conference on Nutrition (Rome, December 1992) containing the World Declaration and Plan of Action for Nutrition; (b) a report entitled Health Dimensions of Economic Reform prepared for the International Forum on Health: a Conditionality for Economic Development (Accra, 4-6 December 1991); and (c) a report entitled A Call for New Public Health Action which is the report of the Saitama Public Health Summit, organized by the World Health Organization and the Saitama Prefectural Government in Omiya City (Saitama Prefecture, Japan, 17-20 September 1991), and which contains the Saitama Declaration.

---

* These documents, in English, French and Spanish, are available for consultation in the files of the Secretariat of the World Conference on Human Rights.

# HEALTH AS A FUNDAMENTAL HUMAN RIGHT AND A WORLDWIDE SOCIAL GOAL

## Part One

1. The purpose of this report is to provide the United Nations Centre for Human Rights with a contribution to the six studies prepared as background documents to the forthcoming Conference on Human Rights. It first gives an account of the World Health Organization's perspective on the implementation of the international covenants on human rights and then provides further reflections on specific rights and issues addressed in WHO's programmes. WHO has a constitutional mandate to act as the directing and coordinating authority on international health work, so as to bring about steady improvement in the public health situation and in the health status of all peoples. This central concern with public health goals and provision of medical services has enabled WHO to keep human rights concern as an integral part of its overall strategies, policies and programmes.

### 1. The right to health for all

2. The WHO Constitution, adopted in 1946, not only defines health as "a state of complete physical, mental and social well-being and not merely the absence of disease and infirmity", but also stresses that "the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political beliefs, economic or social condition". Two years later, the Universal Declaration of Human Rights, which was adopted in 1948 by the General Assembly of the United Nations, reiterated in Article 25 (i) that "everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care, and necessary social services".

3. In May 1977, the World Health Assembly adopted Resolution WHA30.43 which stated that the main social target of Governments and WHO in the coming decades should be the attainment by all citizens of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life. In 1979, Resolution WHA32.30 not only endorsed the report and the Declaration of the International Conference on Primary Health Care held in Alma-Ata in 1978, but invited member States to formulate national policies, strategies and plans of action based on primary health care for attaining the goal of health for all by the year 2000.

4. While the goal of health for all, as well as the basic strategy of primary health care remain valid, new answers are required in a world characterized by rapidly changing political, demographic and socio-economic conditions, poor lifestyles and behavioural patterns, obliging mankind to cope with old, as well as new, health hazards. This led the Director-General of WHO, Dr. Hiroshi Nakajima, to develop a new paradigm for public health action in order to accelerate the achievement of health for all member States and thus health for all people in the world over all phases of their life cycles. Through analysis of the global health situation and related operational issues, some major concerns were identified that countries and the

international health community will have to face well into the twenty-first century. These relate in particular to respect for human rights, especially for the underprivileged, to health and social development, to universal access to care and to promoting health behaviour and lifestyles, including nutrition, using public policy to influence and shape social, economic and physical environments, and to enable individuals and communities to make choices that are positive for health.

5. The political, economic and social changes that have taken place have led to the realization that health and economic development are inseparable, and that development is meaningless without enlarging of people's choices, the essential choices being those which allow people to lead a long and healthy life, to acquire knowledge and to have access to resources needed for a decent standard of living. To achieve such development, it would be necessary, as underlined by the Director-General, to devote more attention to fundamental questions of individual and community rights, indicators of human need, health development and the quality of life, and the application of resources for overall health and human development.

6. While health has lost nothing of its significance as an essential condition for human well-being and development, the goal of health for all requires a holistic approach encompassing all sectors related to human existence, including physical or social environments. Health as a basic human right (and as a condition for human development) cannot be achieved without due attention to the environment with which we continuously interact, such as the social, political, economic or physical environment, including of course, nature with its finite resources.

7. Resolution WHA39.22 (1986) on the role of intersectoral cooperation in national strategies for health for all; the Accra Initiative for Health adopted at the "International Forum on Health: A Conditionality for Economic Development - Breaking the cycle of poverty and inequity"; the report of the WHO Commission on Health and Environment prepared for the United Nations Conference on Environment and Development (Rio de Janeiro, 1-12 June 1992); and the technical discussions during the Forty-fourth World Health Assembly in 1991 on strategies for health for all in the face of rapid urbanization, are all recent examples of WHO's endeavour to provide leadership and guidance in securing the conditions for healthy living and sustainable health development at individual and collective levels. These and other activities are essential components of health protection and promotion, a concept involving a synthesis of various activities that enhance health most effectively when applied in a coherent, consistent and purposeful way. The International Conference on Nutrition in December 1992 constitutes an important milestone in a process which started two years earlier at country level. Organized jointly by the Food and Agriculture Organization of the United Nations and the World Health Organization, the Conference took a comprehensive look at nutrition and resulted in a World Declaration and Plan of Action which will provide the framework for further action at country level that aims at achieving adequate household food security, health and nutritional well-being for all through sustainable an environmentally sound development interventions.

8. The evolution of WHO's concept of health has many implications which influence political, sectoral and professional action aimed at providing all people with the opportunity of being healthy, as a human right. While on one side there is the need to implement strategies that will ensure for the many still deprived, the basic conditions of health, even in the presence of adverse social, economic and other conditions, and on the other side, develop broadly-based, people-centred concepts whereby individuals, communities and societies become motivated and active in the improvement of their own health.

2. WHO goals and the United Nations human rights covenants

9. The goal of Health for All, adopted collectively by all countries at the initiative of WHO, has relevance not only to the provision of health care to everyone but also the provision of care throughout the life of every person, from conception to death. This profound and complete responsibility has a wide ambit: it covers access to knowledge throughout different phases of life about how to live healthily; access to protection against major health risks from others, environment or indeed the result of other development processes; and finally access to suitable promotive, preventive, curative and rehabilitative care.

10. How close and convergent are the WHO goals set out above and those articulated in the International Covenant on Economic, Social and Cultural Rights may be seen from a historical perspective:

(a) Article 25 of the Universal Declaration of Human Rights refers to the right to "a standard of living adequate for the health and well-being ... of the individual and family ... including food, clothing, housing and medical services ... (and) the right to social security in the event of ... sickness, disability ...".

(b) Article 12 goes on to recognize "The right of everyone to the highest attainable standard of health and refers specifically to reduction of infant mortality, healthy child development, industrial and environmental hygiene, prevention and control of occupational, epidemic and other diseases and access for all to medical attention in case of need.

(c) Article 12 arose from a proposal of WHO itself made to the United Nations Commission on Human Rights in 1951; that proposal would have enlarged the present text, with emphasis being laid on (i) inclusion of medical education and training standards and mental health activities as part of Article 12 (2), and (ii) provisions for an undertaking by Governments that adequate social and health measures would be taken to that end, giving due allowance for differences in resources and traditions and for local conditions and disparities among countries in initial levels of development.

(d) The final text for Article 12 did not include item (ii) of the previous paragraph (though Principles for the treatment of the mentally ill became an issue of significance, since successfully resolved with WHO participation in its drafting). It must be recognized that, with dynamic

changes in science, technology and popular expectations, Article 12 might be drafted somewhat differently today. Its emphasis would have been more in keeping with the notion of Health for All through the primary health care approach as adopted at Alma-Ata in 1978.

(e) In 1977, the Thirtieth World Health Assembly adopted a historic Resolution stating that the main social target of Governments and the WHO in the coming decades should be the attainment by all citizens of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life.

(f) Clearly within its constitutional mandate in international health, notably responsibilities for direction and coordination (including development of technical consensus and norms) on the one hand, and technical cooperation on the other, WHO stands committed to keep the human rights orientation as an integral part of its programming. The key to such an integration is a steadfast objective of greater social justice and equity in all countries and to all peoples. The elaboration of this central objective through programmes and policies provided for WHO the necessary scope for implementing human rights concerns set out in the United Nations Covenants.

11. It may be worthwhile at this stage to point out that the traditional instruments for implementation viz. conventions, agreements, regulations etc., though provided for in the WHO Constitution, have not been used for implementing human rights, as in the case of sister agencies dealing, for instance, with the right to work. This distinction arises directly from the nature of issues in health. In so far as health outcomes affect an individual, they are the complex result as much of obligations of State to protect his health as of the very different (ethically charged) obligations of physicians in dealing with patients. There is further the patient's own responsibilities to take care of his own health. These interrelationships are complex and not easy to juxtapose; rapid developments in science and technology affecting medical practice make this position even more complicated. Hence a right to health per se is not amenable to easy definition. Indeed, WHO developed an approach based on consensus building among member countries on such questions as goals, resources and services, taking into account the fact that the political, public policy process, to a large extent, decides health issues.

12. The rapid advances in biotechnology call for renewed concern for human rights promotion and protection in this respect. WHO's activities in the field of bioethics have been conducted in close cooperation with the Council for International Organizations of Medical Sciences (CIOMS). Among the most recent examples of such long-term cooperation one can quote the development of New International Guidelines for Ethical Review of Epidemiological Studies issued in 1991 and the development of revised International Ethical Guidelines for Biomedical Research involving Human Subjects. It is also worth mentioning that in 1991 the Forty-fourth World Health Assembly adopted a set of Guiding Principles on Human Organ Transplantation with the aim to combat trade for profit in human organs among living human beings which is in contravention to the Universal Declaration of Human Rights and the WHO Constitution.

13. Clearly, human rights issues in health arise from both Covenants attracting more individual-oriented issues of patient rights, physician obligations and physician-patient relationships and broader issues involving distributional justice and equity covering groups denied access to health care. Indeed this situation is an earnest of the indivisibility and interconnectedness of civil/political rights and economic/social/cultural rights referred to so often. Despite the trend towards pluralism and market economy, the real disparities in the provision of health for the coverage of poor populations leads to an even greater need for a redefinition of the role of Governments in ensuring optimum equity in health. WHO has the twin responsibility (a) of achieving a technical consensus on courses of action that can be sustained by all countries on a reasonably self-reliant basis, and (b) for translating such consensus into national and global programmes that take due account of vastly diverse social, economic and cultural structures, nurture the scope for maximum international solidarity and strengthen the ways of greater political commitment and resource mobilization within the countries.

14. In searching for such a conscious consensus, experience has revealed, that greatest convergence will occur by concentrating on the right of access to health care. Macrodistributional issues of the due share to public health and its internal priorities are decided ultimately by political forces. Campaigning for due regard to equity of access, could be not only a common rallying point, but also enable more technical options to be identified. The process is often immeasurably slow. Such broad national level distributional decisions would need to be followed by a cascade of subsequent allocating decisions at lower levels in which health personnel have influence; and, as the decision descends closer to individuals in actual need of care, they would be influenced by the culturally validated practices and orientation of health personnel regarding the degree of respect for autonomy and dignity of the individual. By enhancing physicians' capacity to see issues of individual human rights clearly at this stage, it is possible to enhance respect for civil and political rights. There is, however, no doubt that a lasting solution can be reached only if the political public policy process is persuaded to internalize gradually equity approaches to health based on the fact that these socio-economic rights indeed underscore the moral worth of each individual.

15. In its search for fulfilling its mandate for rapid improvement in health status of all countries and peoples, and keeping in mind equal access to care on a sustainable basis as the critical aspect of strategy, WHO had to view the issue of implementation of a right to health as essentially one of mobilizing political commitment to the goal, of strengthening technical cooperation with countries, creating professional consensus around a primary health care strategy calling for intersectoral cooperation, community participation and decentralized decision-making, promoting equity and self-reliance in the process.

### 3. The primary health care approach

16. One of WHO's major contributions to human rights is the collective adoption of the goal of Health for All and of the Primary Health Care (PHC) strategy, calling for mobilization of all resources within nations or

internationally. Health for All was indeed conceived as a complex of strategies and plans of action collectively arrived at by member States and subjected to evaluation and monitoring done through WHO using indicators developed and periodically refined to assess progress. Such a procedure allowed each member State and each WHO Region to take stock of their own circumstances and to formulate their own health possibilities, goals and targets within the principles adopted by WHO at Alma-Ata. The evolution of the PHC approach to Health for All goal was the result of the experience gained from earlier attempts such as health care with a curative orientation and vertical programmes functioning independently to integrated approaches to PHC. The key concern in the ongoing transition to PHC remains as to how to create a sustainable infrastructure with appropriate physical structures and functional capacities to support all programmes as necessary from the disease and vulnerability patterns of the country; for the existence of such a functioning infrastructure is the most explicit guarantee to the poorer regions and groups that access to medical care and minimal health related infrastructure is available. Only then could a PHC system assess the health problems of a population, extend health care to those with special needs and monitor programme effectiveness. Equity and access were conceived indeed as the essence of Health for All and PHC was the mechanism to achieve them.

### 4. Addressing Article 12 (2) of the International Covenant on Economic, Social and Cultural Rights

17. For the details and the implementation of the Covenant by WHO it may be more relevant to look at its technical cooperation programmes elaborated on the basis of HFA/PHC strategy, rather than look to binding regulatory treaty standards and norms. Keeping WHO programmes in mind, we may examine to what extent the four specifics in Article 12 (2) of the Covenant have been realized.

18. As for Article 12 (2) (a), the healthy development of the child has remained a significant focus of attention culminating in the comprehensive convention on the rights of the child. In fact the preamble to the WHO Constitution bears specific reference to mother and child care and healthy development of the child and its ability to live harmoniously in a changing total environment. Health of the child in different ways has remained amenable to initiatives and programmes through joint WHO/UNICEF policy planning.

19. In 1981, the World Health Assembly adopted the International Code of Marketing of Breast-milk Substitutes. The promotion of practices in favour of breast-feeding has been a success in all parts of the world. In 1988, having regard to the stability and coverage achieved in the expanded programme on immunization, the target was adopted for global eradication of poliomyelitis by the year 2000. Maternal and child health and school health programmes figure significantly in WHO support. The perspectives for sustainable programme and future vaccine development as part of the expanded programme of immunization are under constant scrutiny; similarly there has been constant exploration as to how far immunization can be integrated into primary health care.

20. Under Article 12 (2) (b) the Covenant calls for improvement of all aspects of environmental and industrial hygiene. In effect it is symbolic of the right to protection of all peoples against environmental hazards, natural or man-made. In addition to sustained attention to the first generation environmental needs of consequence to public health, such as drinking water and basic sanitation, WHO took the initiative to set up a commission to follow up on the state of knowledge about the effects of the environment on health and available options. The report was both a follow-up to the Bruntland report on environment and a prelude to the United Nations Conference on Environment held in Rio de Janeiro; health aspects arising from long-range environmental changes continue to be a priority for research and investigation. It is, however, realized that the backlog in relation to sanitation and water supply remain significant in much of the developing world, the former more so. Under its norm setting role, WHO has laid down water quality standards and continues to participate closely in global environmental monitoring activities. The effects of nuclear radiation on health following the Chernobyl accident led to a WHO initiative for the setting-up of an international centre for studying the effects of the disaster; the database and the transparent exchange of information in this regard would remain a significant scientific contribution, of as much significance to the right of individuals to life and to protection from environmental hazards.

21. The remaining two provisions of Article 12 (2) concern the prevention, protection and control of diseases and the availability of medical attention and services to all in times of sickness. Together they constitute the traditional core of WHO's objectives and activities. In 1977 the World Health Assembly resolved that the main social target of Governments and of WHO should be the attainment by all citizens of the world by the year 2000 of a level of health that would permit them to lead a socially and economically productive life. In 1978 the International Conference on Primary Health Care, held in Alma-Ata, USSR, affirmed that the primary health care approach was the key to attaining this target.

### 5. The health for all strategy

22. The Thirty-second World Health Assembly endorsed the PHC approach in using health as a powerful lever for socio-economic development and peace and for attaining the goal of health for all by the year 2000. In 1981 the Global Strategy for Health for All was adopted by all member States collectively according to the following policies:

> The basic policies embodied in the Strategy are that health is a fundamental human right and a worldwide social goal; health is an integral part of development; the existing gross inequality in the health status of people is of common concern to all countries and must be drastically reduced; people have the right and the duty to participate individually and collectively in the planning and implementation of their health care; Governments have a responsibility for the health of their people; countries must become self-reliant in health matters; and fuller and better use must be made of the world's resources to promote health and development.

23. The collectively agreed goals contained the common elements of essential care, community involvement, appropriate technology and intersectoral cooperation. The significance of the strategy was the degree of flexibility allowed to member States to decide on their own strategies and plans of action within the collectively agreed principles, the non-negotiable essence for access to and quality of care, which should encompass preventive, promotive, curative and rehabilitative tasks. The concept of primary health care, as outlined in the report of a joint WHO/UNICEF conference in Alma-Ata, USSR, in 1978, was a breakthrough towards a worldwide movement to reduce the gap between "haves" and "have nots" popularly known as Health for All by the Year 2000 (HFA 2000).

24. Primary health care is essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford ... It forms an integral part both of the country's health system, of which it is the central function and main focus, and of the overall social and economic development of the community.

25. The second evaluation of implementation of the Global Strategy for Health for All by the Year 2000 has just been completed. It shows that there have indeed been achievements over the past few years; it also reveals just what gaps remain, especially between the rich and the poor.

26. Achieving the goal of health for all by the year 2000 requires concerted efforts from countries to organize their health systems based on PHC. The past decade has seen both solid progress and serious setbacks. Some countries maintain a priority commitment to PHC and can demonstrate success in improving the accessibility and quality of health care. In others, falling living standards, massive indebtedness, and ecological decline have had a negative impact on both health services and health status.

27. A health system consists of interrelated components that contribute to health in homes, educational institutions, workplaces, public places, and communities, as well as in the physical and psychosocial environment and the health related sectors, like agriculture, education, environment, etc. A health system is usually organized at various levels, starting at the peripheral community level or the primary level of care, and proceeding through the intermediate (district, regional, or provincial) level to the central level. At the same time it includes individuals and families taking an active interest and participating in solving their own health problems, thus becoming full members of the health team. The intermediate and central levels deal with those elements of the health system for which they are given responsibility by the country's administrative organizations, and they also provide progressively more complex and more specialized care and support. It is only through such a coordinated mutually reinforcing set up that all members of society can realize their fundamental rights to levels of health care according to need and get referred to the appropriate level when necessary.

## 6. Disparities in health

28. In the 10 years since the Global Strategy was adopted by the World Health Assembly, and the 6 years since the first evaluation, health status - as measured by such indicators as life expectancy and infant mortality - has improved globally. However, the pace of improvement has been distinctly slower for the least developed countries and, as a result, inequities between the developing and least developed countries are greater now than they were a decade ago. These disparities when disaggregated highlight unacceptable conditions at the periphery where the poor and the underprivileged are most at risk.

29. The availability of essential health care has also increased globally. Yet, millions of people remain without access to either all or some elements of care. If the availability of certain elements of care increases, while the availability of other complementary elements does not, the positive impact on health status of the one, can be offset by lack of the other. Similarly, if the infrastructure is expanded but the means to use that infrastructure to provide care is weak, no improvement in health status will be evident. In other words, in the development of health systems based on primary health care, the right things are being done, but not necessarily in all instances in the right form.

30. The underlying common cause of infrastructure deterioration is the poor economic performance of countries. The most common policy response, aimed at restoring economic growth by eliminating deficits in the Government's domestic and foreign trade situation, has frequently meant disproportionately large cuts in social expenditure. In too few countries can this policy response be shown to have restored growth, nor has the design and operation of "safety nets" to support those hardest hit by social sector cutbacks been easy or failure-proof.

31. The neglect of health infrastructures, both as a result of structural adjustment policy and of the recent focus of donor interest on selected actions for priority problems, now threatens not only the long-term goals of Health for All, but also the widely accepted strategies for achieving these goals. These strategies include a pluralistic and developed approach to health development, with a revitalized public sector regulating and coordinating governmental and non-governmental sources of health care financing and provision, and increased local autonomy and public accountability.

32. It can be stated that improvements have been made in health status in terms of life expectancy at birth and infant mortality rates, and coverage levels by various elements of primary health care. Because such improvements seem to be more rapid in the developing countries than in the least developed ones, the disparities in health status between the developed and developing countries appear reduced but those between the least developed and other developing countries have increased. There is also some evidence that disparities in health status have increased within countries between certain population groups. Coverages by various elements of primary health care have sometimes been unbalanced and distorted, thus having insufficient impact in terms of health.

33. Looking to the future, there are strategies that are essential if we are to reduce the gaps between the rich and the poor and ensure that all people enjoy their right to social justice and equity. Austerity measures adopted in response to economic recession should be implemented in ways which protect the poor as much as possible. Targets should be pursued for reducing disparities in health status and access to health services. National policies are often notable for their reluctance to face up to key decisions that will directly help the poor or at the least not make them worse off. Often, this is due to the absence of a consistent policy frame and to the grave lack of resources available.

34. WHO, in collaboration with other agencies, will continue to play an important role in mobilizing information, skills, and technical support for strengthening health systems by supporting research and development on country-specific priorities; by supporting the development and use of tools, procedures and methodologies, as well as institution strengthening; by fostering an exchange of information and experience, by fostering partnership.

## 7. Equity in health

35. The concept of equity in health and the right to health both together constitute an enlarging of human rights' consciousness for which the time has come. The forthcoming Conference must provide an occasion for major international institutional reflection on how close human rights and unmet basic needs can converge. Such reflection might influence to good purpose strategies for the current international development decade, besides elaborating the rights themselves.

36. As a concept, equity in health has a complex overlay of meanings. It should, of course, be distinguished from the notion of equality, for the latter refers to equalization of differences in outcomes, quality, status or inputs. The distinguishing feature of equity is an ethical dimension providing norms for action and, in turn, provoking thought on alternative perspectives for the determination of such norms. Equity in health would broadly seek to redress differences which are not only unnecessary and avoidable but are at the same time unjust and unfair. These may be differences in level of health or quality of life which involve wider socio-economic or developmental variables, or they may be differences in services or in access to health care.

37. Equity in health implies that everyone should have a fair opportunity to attain full health potential - over a period of time and throughout one's life cycle. One can operationalize this approach only if equal access to available care remains the guiding principle.

## 8. Holistic view of the right to health

38. The right to health as part of a group of economic, social and cultural rights is already enshrined in the Covenant on Economic, Social and Cultural Rights, and all rights inscribed in both Covenants are to be realized in an interconnected and indivisible manner according to repeated averment. It could be said that the right to health seen as a composite right, consists of a large number of "surrogates", each one of which could become a right in

itself. Indeed, the concept of "right to health-care", "right to social security", "right to reliable services from a functioning social infrastructure" or the "right to redress against iniquitous action" could well constitute the first level of such surrogates. In turn, each of these surrogates, whether enshrined as a right, in the constitution and the law or as judicial or administrative procedure, part of a citizens' charter or otherwise, would indicate what citizens can demand through appropriate authorities either as an outcome or procedure. The right to health-care means an equal opportunity for everyone to have recourse to due medical care, to educational counselling, to preventive protection from public health hazards, and to the creation of conditions, through regulatory or other devices, to a reasonable expectation for an equitable share in total health-care resources. Medical care always constitutes a primary foundation of a right to health. The basic right of access to medical services and attention is totally in accordance with Article 12 (2) (d) of the International Covenant.

39. No doubt rights to social security, reliable social services and redress against inequity are common to the enjoyment of many rights, not to the right to health alone. The advantage of picking on these "surrogates" for elaborating the right to health is the possibility that within each relatively narrow field of action, appropriate indicators of progress could be identified and periodic trend surveys of the achievement of such indicators could provide evidence of the evolving nature of the right to health. In fact, formulated in such a composite manner, there is a possibility that the situation in regard to the enjoyment of the right to health, in both developed and developing countries, can be tested on reasonably similar yardsticks always having due regard to differential initial bases. To accomplish this, the health sector as a whole needs alliances; and it will stand to gain from allying to its objectives, the influential pressures born of current human rights concerns covered under both Covenants thus gaining universal acceptance. The rights covered by the two Covenants must be viewed holistically to guarantee individual and community rights and values.

## Part Two

### 1. The rights of patients

40. Reaffirming fundamental human rights in health care, and in particular protection of the dignity and integrity of the patient as a person, is particularly important, since the vulnerability of sick persons renders them easily subject to violations of their rights and more readily affected by gaps and shortcomings of social and health administrations.

41. Various social, economic, cultural, ethical and political considerations have given rise to concern for a fuller elaboration and realization of patients' rights. New and more positive concepts of patients' rights are being advocated. In part, this has been a reflection of the central place given both to full implementation of the concept of respect for persons and to equity in health as a policy objective in WHO's Member States. As a consequence, there is now greater emphasis on, inter alia, the encouragement of individual choice and the opportunity to exercise it freely, and the commitment to build mechanisms for ensuring quality of care.

42. Developments within health care systems, such as the increasing complexity and often the growing bureaucracy, as well as developments in medical and health science and technology, have all prompted a new emphasis on the importance of recognition of the right of the individual to self-determination and, in many cases, the need to formulate guarantees to assure patients' rights. Governments are increasingly giving active consideration to such issues as the provision of information to the patient, informed consent, confidentiality and privacy, data protection, access to medical records, the right to health care and relief of suffering, respect for human dignity and cultural and religious values and the availability of institutional mechanisms for dealing with patients' complaints.

43. In this sense, a highly distinctive feature of the present time is the development not only of the individual but also the social dimension of patients' rights, taking into account living and working conditions and public health in its broad sense. Hence derives the trend to reaffirm the right to treatment and care, to adequate social cover and to proper information about health services, in other words, the right to benefit from progress in the health field. Account needs to be taken not only of the changing mentality of a public that aspires to becoming not merely users but also active partners in sharing responsibility for the health system as a whole. Inseparable from this social approach is the growing impact of economic factors on health policy and management, and the growing recognition of the limits imposed on the provision of health care as a result of economic constraints. The resulting challenge is a search for ways to curb rising costs without undermining the basic right to health of the population in terms of access to care and services, equity in treatment and quality of care.

44. Another factor that is greatly influencing the recognition of patients' rights is to be found in the very manner in which modern medicine functions, with the dispensing of care becoming increasingly complex and changing so rapidly that it generates in adaptation of the health care system. This is the case, for instance, in the way hospital care is structured, with its harsh and complex realities as experienced by the patient. Modern medicine also tends to foster both excessive bureaucracy and situations that may give rise to conflicts. The imperatives of management, or profit, can be at odds with the well-being of patients. Despite certain established principles of respect for patients of a fairly protective nature, it is undeniable that users' expectations are not being met. This is widely attested by the numerous petitions and claims made and by the emergence of consumer associations and pressure groups that highlight the practical difficulties met in implementing patients' rights.

45. Finally, the factors that have contributed to a new recognition of patients' rights certainly include the appearance of a "new biomedical ethics", or bioethics, aimed at reconciling the imperatives of research indispensable to the improvement of care techniques, with the protection of the fundamental rights and freedoms of individuals participating in research on human beings. This concept of bioethics is one that is also shaping the attitude of the individual patient, as well as of others involved, in crucial decisions pertaining to life and death and which demand respect for fundamental ethical principles.

## 2. The rights of the mentally ill, and the improvement of mental health care

46. On 17 December 1991, a set of Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care was approved by the United Nations General Assembly (resolution 46/119 of 17 December 1991). WHO considers these Principles to be a landmark achievement of the United Nations system. The Principles provide comprehensive protection for a particularly vulnerable group that is readily susceptible to stigmatization. Persons in this group are vulnerable because of their disturbed mental state, which prevents them from making reasonable judgements about their own needs; and, as a corollary of their vulnerability, such persons are often given least priority in terms of access to care and services. It is true that mentally ill persons can sometimes be dangerous to themselves or to others, although this hazard is often exaggerated. The Principles attempt to set forth due safeguards against such hazards, without ignoring the fact that such provisions are particularly liable to be abused by family members, other members of the community or State authorities. If a national jurisdiction follows this balanced set of Principles in drafting domestic law and in instituting procedural modalities, both the rights of the mentally ill and improvements in mental health care can be accomplished. Just as WHO played a prominent role in assisting the Commission on Human Rights in drafting the Principles, it could certainly take the lead in disseminating them to its vast network of professional contacts, so that national systems evolve with sensitive consideration to all aspects of the problem.

47. It is not the task of WHO to monitor the implementation of the Principles, and any possible abuses of the rights of the mentally ill. This should, quite appropriately, be left to non-governmental groups and other independent bodies. Indeed, such groups and bodies should constitute a decentralized human rights monitoring network. WHO's responsibility will be to provide technical advice to the health authorities of Member States, at their request, so as to enable them to adjust their services to function in ways that are consonant with the Principles. WHO is also in a position to cooperate with countries in amending their mental health laws in line with the Principles.

## 3. The rights of the child

48. The Convention on the Rights of the Child represents, as far as WHO is concerned, an affirmation of the validity of the definition of "health" included in the Preamble to the WHO Constitution. In addition to providing a legal framework for the protection of children, the Convention covers specific health and family planning needs of the mother, in addition to direct health-promotion and disease-prevention requirements of the child. This inclusion of maternal health within the framework of children's rights reflects the recognition of the social, psychological and biological bonds between mother and child. The rights of children to health care are not merely a matter of access to preventive and curative medical technologies, drugs, etc. In order for the child's health rights to be realized, many other provisions in the Convention need to be implemented; it must, in particular, be assured that activists in other sectors, do not compromise or neglect health when they formulate projects, activities, or even laws or regulations.

WHO is actively pursuing its responsibilities to assist States Parties to the Convention to realize and maintain the health-related rights set out in Article 24 of the Convention, and indeed progress in this respect forms part of WHO's endeavours to monitor progress towards the goal of Health for All. In association with UNICEF and the International Paediatric Association and other non-governmental organizations, WHO has been active in advocacy and support for ratification, implementation and monitoring of the Convention.

49. Children in vulnerable and difficult circumstances, street children, and children subject to exploitative child labour, have special health needs that are not readily met by existing health structures. Even more difficult has been the ability to respond to the needs of children caught up in conditions of civil conflict. Together with other recognized humanitarian organizations and agencies, WHO has been engaged in providing and coordinating emergency relief programmes for such children.

50. Monitoring activities have revealed significant successes in regard to immunization coverage of children. However, WHO is also aware of large and continuing disparities in pockets, particularly in Africa, where more women are dying in childbirth and more infants are born malnourished in utero than five years ago.

51. Scientific information on the adverse effects of child labour on the health of the child is limited. In the vast majority of work situations, important features of child labour that affect health, such as the "critical age" during which the child is more liable to the hazardous effects of labour, the duration of specific forms of work, and the type of work causing damage to child health, have not been scientifically documented and much more needs to be done in this area.

52. WHO has been involved in research, training and developmental aspects of action programmes in the area of child labour since 1980. The objectives have been as follows: (a) to define possible health implications of child labour; (b) to make recommendations for relevant intersectoral action; and (c) to prompt greater cooperation among individuals and groups working in the field of child labour and its health implications, including the provision of technical support. Scientific reference should be made to an informal Inter-Agency Task Force, which is being reactivated and whose members include Defence for Children International; the ILO; the International Society for Prevention of Child Abuse and Neglect; UNICEF; and WHO. WHO intends to continue to provide technical support and to disseminate information on the relationships between child labour and health. It intends to advocate and promote intersectoral action programmes, in close cooperation with other agencies and non-governmental organizations.

### 4. The rights of the elderly

53. A number of human rights concerns in respect to the care of the elderly are set forth in the Preamble to the International Plan of Action on Aging, held in Vienna on 26 July-6 August 1992, and is currently the principal international instrument that guides policies and programmes in this area.

54. The elderly, defined in 1991 by the Bureau of the Census, Economics and Statistics Administration of the United States Department of Commerce, as persons who are 60 years of age and over, currently account for between 17 per cent and 23 per cent of the population of most countries in the developed world, and for 5 per cent to 10 per cent of the population of countries in the developing world (in a few developing countries, the percentage is higher). Of great interest is the fact that it is this segment of the world's population that is growing most rapidly; by far the greatest increase is taking place in the developing world. For example, according to Golini and Lori (in Aging, 2: 319-336, 1990) the percentage of the population 65 years of age and over is projected to triple in China and quadruple in the Republic of Korea and Malaysia by the year 2025.

55. The elderly have distinct human rights, which were not addressed specifically in the 1948 Universal Declaration of Human Rights or other relevant human rights instruments. Indeed, the elderly represent a minority that all of humanity hopes to join, in contrast to other minority groups such as the disabled, refugees and ethnic minorities that remain distinct throughout life. Various forms of "ageism" may lead, in the event of medical care, to misdiagnosis, inappropriate treatment, and unnecessary institutionalization. Health and well-being of the elderly can be assured only through a better understanding of the subtle and pervasive effects of age-related discrimination in all its forms.

56. Two notable instruments merit particular mention: the ILO's Older Workers Recommendation, 1980 (Recommendation No. 162), addresses the right of all workers, liable to confront special difficulties in employment and occupation because of advancement of age. This is of special importance as the elderly are not a homogeneous group with respect to levels of physical and mental health. The other is United Nations General Assembly resolution 46/91, adopted on 16 December 1991, which sets forth "United Nations Principles for Older Persons". The latter text identifies 18 key principles relating to independence, participation, care, self-fulfilment and dignity. In the area of care, for example, the resolution stresses the right of an older person to benefit from family support and access to health care, and to retain fundamental human rights and dignity if residing in a treatment or care facility. Guidelines are required to implement these Principles. WHO intends to participate fully in the development of such guidelines.

### 5. The rights of the disabled

57. WHO has promoted the rights of people with disabilities through community-based rehabilitation (CBR), a strategy for ensuring that rehabilitation is available to disabled people in the same way that health services are available to all people in the community. CBR includes the transfer of knowledge and skills for rehabilitation activities to disabled persons, their families and the community, and the integration of disabled children into school work and adults into social settings within the community. The support required for CBR is multisectoral, and involves in particular the health, education, labour and social services. WHO remains committed to work with other United Nations agencies, Governments, and non-governmental organizations to promote the expansion of CBR and the necessary support services.

## 6. Human rights aspects of HIV/AIDS

### A. The protection of human rights and the Global AIDS Strategy

58. In May 1992, the Forty-fifth World Health Assembly endorsed an updated, expanded, and refined global strategy for the prevention and control of AIDS; this establishes the new direction to be taken by all partners in the global efforts to combat AIDS in the years ahead. The Strategy sets out ethically and technically sound approaches, of known effectiveness, for meeting the new challenges posed by the pandemic, viz.: increased emphasis on care; better treatment for other sexually transmitted diseases; a stronger focus on HIV infection through an improvement of women's health, education, and status; a more supportive social environment for prevention programmes; anticipatory planning in respect of the socio-economic impact of the pandemic; and greater emphasis on the public health dangers of stigmatization and discrimination. The three main objectives of the Strategy are identical to those of the original (1987) version of the Strategy: (a) to prevent infection with HIV; (b) to reduce the personal and social impact of HIV infection; and (c) to mobilize and unify national and international efforts against AIDS.

59. In implementing this Strategy, WHO's Global Programme on AIDS (GPA) is continuing to unify and mobilize international efforts in the area of human rights and HIV/AIDS. For example, GPA has participated in international conferences on HIV/AIDS, convened or supported seminars on the subject, cooperated with the United Nations Centre for Human Rights and with other United Nations agencies, played an advocacy role with Governments, supported and funded non-governmental organizations, and financed a number of studies, all focusing on the human rights dimensions of AIDS. At international and national conferences, GPA has continued to ensure that the promotion of human rights for people with HIV/AIDS remains on the agenda, both internationally and nationally. Resolution WHA41.24, adopted by the Forty-first World Health Assembly in May 1988, called upon WHO to take all measures necessary to advocate the need to protect the human rights and dignity of HIV-infected people and people with AIDS. As part of GPA's objectives in respect to advocacy, WHO has decided not to sponsor, co-sponsor, or financially support international conferences or meetings on AIDS in countries having HIV/AIDS-specific short-term travel restrictions.

60. As regards education, GPA has conducted human rights-oriented training programmes for its own staff at WHO headquarters in Geneva, and is planning to hold similar seminars for WHO staff in the Organization's six regional offices. Moreover, it has held a series of consultations on human rights aspects of HIV/AIDS, in such areas as: short-term travel restrictions; prisons; and testing. Furthermore, GPA supports WHO's Health Legislation Unit, which regularly produces a tabular listing of HIV/AIDS legislation (see "Tabular Information on Legal Instruments Dealing with HIV Infection and AIDS" (WHO/GPA/HLE/92.1, June 1992); an update is scheduled to appear in June 1993). Consideration is being given to the establishment of other databases dealing with HIV/AIDS and human rights.

61. As regards cooperation with international organizations, GPA has cooperated closely with other United Nations agencies that are involved in human rights issues, including the United Nations Centre for Human Rights, the ILO, UNHCR, and UNDP.

62. With regard to advocacy to Governments, WHO has provided technical cooperation, discussed proposed and enacted legislation, and responded to requests for information from Governments on human rights and on HIV/AIDS laws and regulations. It is developing a course for AIDS Programme Managers (i.e. government officials who serve as national focal points for AIDS), where a component of the course will deal with training on the promotion of human rights. GPA also reviews Medium-Term Plans prepared by Governments, so as to ensure the promotion of human rights. Finally, GPA is cooperating with non-governmental organizations, and has funded and is continuing to fund NGO work on human rights; it regularly responds to inquiries from NGOs concerning the human rights aspects of HIV/AIDS.

## B. Perspective actions

63. The AIDS pandemic is still increasing. Associated with the pandemic is the profound negative personal and social impact of discrimination. Non-discrimination is good public health policy. Fortunately, sustained and effective advocacy can play a powerful and positive role in avoiding discrimination against persons with HIV infection and AIDS. It may be affirmed that success in the campaign against AIDS will to a significant extent be measured on how well Governments throughout the world implement non-discriminatory policies and practices.

64. Discrimination against HIV-infected persons and persons with AIDS continues to be a major obstacle to the prevention of HIV infection and the provision of care for persons with AIDS, and is also retarding efforts to reduce the personal and social impact of HIV infection and AIDS.

65. GPA's human rights activities build on prior accomplishments, viz.: the establishment of a worldwide information-sharing network, with a central information bank on HIV-infected individuals whose human rights have been violated; distribution of guidelines on HIV/AIDS in prisons; compiling documentation on legal instruments dealing with HIV/AIDS; collaboration with other United Nations agencies engaging in human rights activities; maintaining and expanding the existing collection of reference documents and database of human rights aspects of HIV/AIDS; producing other operational and training materials in this area; and training key decision makers at the country level (e.g. AIDS programme managers, government officials, and NGOs) concerning issues relating to discrimination against HIV-infected persons and people with AIDS (emphasis in such training will be placed on the significance and value of human rights promotion in accomplishing AIDS-specific public health objectives).

66. GPA will continue to conduct (in cooperation with the United Nations and other specialized agencies) meetings and consultations designed to develop and formulate standards and norms that can be relied upon for advancing human rights objectives and avoiding discriminatory practices. These include

policies, guidelines, and norms on HIV/AIDS and human rights in those areas in which discriminatory practices have a significant impact, for example in: international travel and migration; the workplace; and other areas to be determined.

7. The rights of vulnerable groups and indigenous peoples

67. The goal of Health for All by the Year 2000 is, in the final analysis, about the underprivileged. Thus, in order to achieve the goal, it is essential to identify the underprivileged in each country, whether developed or developing; it must cover those who are currently excluded from the word All in order to make sure that they are included as soon as possible - at least by the year 2000.

68. Population groups that have been found to be underprivileged as far as health is concerned include: disabled persons; the unemployed; commercial farm labourers; the lower castes; indigenous populations; homeless persons; one-parent families; migrants; large families; population groups residing in remote areas that are not readily accessible; orphans and street children; and persons who are illiterate. Many of these underprivileged groups do, of course, overlap.

69. The major differences in levels of health are of concern for several reasons. Firstly, because substantial progress has been made in improving health in the aggregate. Secondly, few countries have data on the health of socially and economically underprivileged groups that are adequate and reliable enough to monitor differences in trends. Thirdly, from the few instances where such data is available, it is clear that the gaps are stable or even increasing. One of the targets of the countries in WHO's European Region, viz. by the year 2000 the actual differences in health status between countries and between groups within countries should be reduced by at least 25 per cent, by improving the level of health of disadvantaged nations and groups, will not be achieved. On the contrary, if the health situation is compared between countries, there is an increasing gap between North-Western and Central-Eastern Europe, with Southern Europe occupying an intermediate place in most respects. Closing this gap as far as possible, probably to level of differences which existed at the beginning of the 1970s, is the task for the coming decades. Another example is from the United Kingdom, where the 1992 Black Report entitled Inequalities in Health concluded that the relative differences in mortality of unskilled manual workers as compared with professionals and managers did not narrow in the 20 years between 1950 and 1970 and in some cases actually widened.

70. A fourth reason is the current inertia to undertake fundamental reforms to improve the health of the underprivileged. Although the intrinsic reasons for the differences are not precisely known, enough is known to ameliorate the situation where there is indicative primarily of weak political will. Studies in developed countries have shown that excess mortality is due to accidents, cardiovascular diseases, and unhealthy living and working conditions, for which a number of specific preventative measures can be instituted. In the developing countries, readily preventable diseases (including malnutrition,

infectious diseases and problems associated with pregnancy) are responsible for the gaps. Many of these countries have to confront a double jeopardy, in so far as they have to content with the burden caused by non-communicable diseases even while efforts to combat communicable diseases are far from complete. In spite of these major factors, an equity-supported social policy and "health transition", including a rapid decline in morbidity and mortality from high to fairly consistent low levels is feasible, and has indeed occurred in a number of countries with a low GNP, such as Sri Lanka.

71. Under the terms of Article 20 of ILO Convention No. 107 (Convention concerning the Protection and Integration of Indigenous and Other Tribal and Semi-Tribal Populations in Independent Countries) requires Governments to assume responsibility for providing adequate health services for the populations concerned. WHO has constantly made its position known with regard to these provisions, and has pointed out that they are in line with WHO's own Constitution.

72. As the year 2000 approaches, it is urgent that new strategies be developed to improve the health of underprivileged people. These strategies will include: overcoming inertia; establishing broad-based intersectoral action; establishing targets; ensuring community participation; and learning-by-doing. The content of each of these strategies will vary between developed and developing countries. Strategies will have to deal mainly with overcoming cultural and individual financial barriers to utilization of health care (based on the existing infrastructure), the promotion of healthy lifestyles, and the achievement of greater equity in the distribution and allocation of resources. Support from the developed countries to address the needs and rights of vulnerable groups and indigenous peoples is needed to find new ways of overcoming entrenched problems. Within individual countries, this implies a willingness to recognize the problems and to actively search for data on the epidemiological contours of the problem, as well as a political will to design strategies and policies that ensure at least a minimum level of income and employment. The health sector needs to promote and support such broad-based approaches and initiatives, that are fully within the mandate of the sector itself.

73. One can see a number of problems ahead. The formulation of health targets for vulnerable groups and indigenous peoples may give rise to political problems in the present context, where there are a number of international and national political conflicts involving minority groups. The term "underprivileged populations" may itself become an issue. Whether this or another term is used, it should engender concern, and stimulate a need for urgent action within the framework of efforts to achieve Health for All. In dealing with the issue of the health of vulnerable groups and indigenous peoples, there are bound to be strong and sometimes differing views on how to deal with the issue, as well as vested interests in maintaining the status quo. Consequently, as compared with the past, the health system is likely to enter an area of some instability.

## 8. The health status of least developed countries

74. As a follow-up to the Second United Nations Conference on the Least Developed Countries (Paris, 3-14 September 1990), WHO has taken the initiative in giving holistic attention to the continuing adverse level of health in the least developed countries (LDCs). This is in line with the Declaration of Alma-Ata, in the sense that international solidarity to cope with disease and ill-health in one part of the world is of importance to all countries.

75. All the socio-economic indicators, and particularly the health indictors, are "in the red" in the LDCs: life expectancy is under 50 years, as against 74 years in the developed countries; and 150 children in every 1,000 die during the first year of life, compared with 15 in the industrialized countries. Barely two deliveries in five are supervised by qualified personnel. It is scarcely surprising that, under such circumstances, some 500,000 women die in childbirth every year in the developing countries. In addition, the burden of AIDS, closely related as it is to poverty and ignorance, can be expected to have a significant negative impact. Of the estimated 11-13 million HIV infections throughout the world, at least half are in the LDCs. What this implies is that about one in every 80 adults in these countries is HIV-positive. If we consider the LDCs in Africa alone, this proportion increases to about one in 40.

76. The fact that the LDCs have not yet succeeded in meeting the basic health needs of their people should not be concealed. In fact, during the decade of the 1980s, the demand for health services in these countries increased, while the supply diminished. WHO considers this kind of imbalance to be unacceptable. It is the Organization's view that, in order for it to be corrected, substantial investments in health will have to be made in the LDCs by the end of the century.

77. While primary health care (PHC) remains the optimal method for enabling the LDCs to make progress towards the goal of Health for All, its implementation requires a firm commitment on the part of political leaders at the highest level to reduce social inequities. But how can these countries hope to develop PHC when three quarters of the funds available for health are spent on hospitals in cities, benefiting only a tiny proportion of the population? Aware of the difficulties and obstacles encountered by the LDCs in trying to implement PHC effectively, WHO has launched a new initiative aimed at concentrating efforts on the countries and populations in greatest need. The aims are to improve the integration and coordination of WHO's programmes within a country, and to bring activities more closely into line with national health priorities. Special emphasis is laid on the need to help these countries increase their capability to deal with the analytical, managerial, economic and financial aspects of health strategies.

78. This new approach by WHO presupposes a commitment by the national authorities to take a new and realistic look at their health priorities and their resources. Within this intensified cooperation, the establishment by the national authorities of rational, realistic and consistent health plans that are based on resources actually available, provides a logical framework within which these resources can be used more effectively for the country's development.

79. WHO has already analysed in-depth the situation of 23 countries, including 18 LDCs, and technical and financial commitments have been entered into with countries such as the Central African Republic, Chad, Djibouti, Guinea, Guinea-Bissau, Malawi, Nepal, Sudan and Yemen. In the short-term, efforts are being made to speed up the control of certain diseases (meningitis, malaria, tuberculosis, and leprosy), to overcome the inadequate supply of equipment and essential drugs, and to provide Governments with technical experitise on urgent issues. In the medium- and long-term, the objective is to harmonize activities, to overhaul and strengthen the health sector within the b=national economy, and to promote national self-reliance.

80. It is WHO's conviction that there is no other possible choice if it is to take up the challenge of the intolerable persistence of high rates of mortality and avoidable diseases in the LDCs. Their persistence is intolerable to WHO because it is thwarting the efforts for "the attainment by all peoples of the highest possible level of health", the Organization's constitutional objective. The international community must consequently make a greater commitment by mobilizing a willing and active partnership that is capable of breaking the "vicious circle of disease and poverty" and constructing in its place a "spiral of health and development".

## 9. The role of health legislation

81. The contribution of health legislation in improving the health of the community, at least in the developed countries, has been significant. As the editorialist of one of the most distinguished medical journals put it some 15 years ago:

> "Public-health legislation and related measures have probably done more than all the advances of scientific medicine to promote the well-being of the community in Britain and in most other countries." (Lancet, 2, 1978).

No doubt the term "well-being" is to be interpreted in the same comprehensive way as in the first of the principles declared (in the Preamble to WHO's Constitution) to be "basic to the happiness, harmonious relations and security of all peoples". Can this contribution of "legislation and other measures" be quantified? What about the "minority of countries" to which the editorialist implicitly refers? Are there intrinsic or extrinsic factors that have prevented health and related legislation from playing its due role in advancing community and individual health? These are some of the questions that merit careful consideration by human rights scholars, in conjunction with public health leaders, ethicists, moral philosophers, and others.

82. As far as is known, contemporary medical curricula in most countries generally accord little place to the language and literature of ethics, and less to the principles of human rights enshrined in the International Bill of Human Rights and in other international and regional human rights instruments. Practising physicians hence tend to be unaware of the health-related human rights to which their patients or the community which they serve are entitled. How many, for example, are familiar with paragraph 16 of the Proclamation of Teheran, in spite of its relevance to family and child health throughout the world? How many are aware that the International Conference on Human Rights,

held in Teheran on 22 April-13 May 1968, urged "all peoples and governments to ... redouble their efforts to provide for all human beings a life ... conducive to physical, mental, social and spiritual welfare" (language that partially echoes the definition of "health" embodied in WHO's Constitution)? Does Article 12 of the International Covenant of Economic, Social and Cultural Rights mean very much to the health policy makers in developed or developing countries? This disjunction could perhaps be ameliorated by an effort, on the part of interested organizations, to produce a manual on how the philosophy and principles of those human rights that related to human health - in the widest sense - can be incorporated in the medical curriculum. (Important pioneering work has been accomplished by the Council of Europe and the Trieste-based International Institute for Human Rights Studies. See, for example, Le Médicin Face aux Droits de l'Homme. CEDAM, Padua, Italy, 1990). This would be accompanied by another product that would guide legislators and health administrators on how to translate these principles into enlightened health legislation, in line with WHO's Health-for-All Strategy and at the same time imbued by the ideas of René Cassin, Eleanor Roosevelt, and other progenitors of contemporary human rights.

83. It may be argued by some that the very language of Article 12 is "dated", and reflects the generally prevailing philosophy of health at the time. It contrasts with the much more progressive, and equity-centred, language of (for example) the 1988 Protocol of San Salvador to the Pact of San José (Organization of American States). It would be illusory to suggest that Article 12 be revised to reflect what might be described as the philosophy of Alma-Ata (after the city of Kazakhstan at which the WHO/UNICEF International Conference on Primary Health Care was held in September 1978), and the emerging new health paradigm being developed under WHO's leadership. What would be less illusory, perhaps, would be the development of a scholarly guide to the implementation of Article 12 (possibly also embracing Article 25 of the Universal Declaration of Human Rights) in the light of contemporary approaches to health and to the health (and associated environmental) problems with which the societies of the twenty-first century are likely to be confronted.

84. As suggested above, the Lancet editorial implicitly identifies two groups of countries - one in which health legislation has greatly improved the public health, and one in which it had failed to do so (at least as of 1968). If this is indeed the case, can the gap be due to factors that can (1) be identified, and (2) be remedied by the global health community? Is the still-prevailing colonial legislative heritage to blame? Are there discernible constraints in terms of manpower, resources, or other elements? These are questions that merit an answer or at least in-depth study by the academic community in conjunction with interested international organizations.

85. The need for studies on "protection of the human personality and its physical and intellectual integrity, in the light of advances in biology, medicine and biochemistry" was noted by the General Assembly in resolution 2450 (XXIII), adopted on 19 December 1968. (See in this connection the WHO study entitled Health Aspects of Human Rights with Special Reference to Developments in Biology and Medicine (1976) and United Nations Commission on Human Rights document E/CN.4/1172 and Add.1-3 of 1975 entitled "Protection of the human personality and its physical and intellectual integrity in the light of advances in biology, medicine and biochemistry"). The intervening

quarter of a century has witnessed substantial national legislative activity designed to assure such protection. What is perhaps required at this juncture is a determination of the effectiveness of the legislation enacted to date, and the emerging areas in which legislative intervention, international, regional, or national, may be called for.

86. The time may well be opportune for the agencies in the United Nations system concerned with social and cultural rights (notably UNESCO, FAO, ILO, WHO, and UNFPA) to endeavour to formulate jointly agreed guidelines on the implementation of these rights by national legislation. All these agencies have been actively engaged in strengthening national legislative capacities in their respective sectors. All have gained much experience on alternative approaches to legislation, and a common effort to provide guidance to countries could yield useful results.

### 10. Humanitarian emergency health assistance and rights of displaced populations

87. The Preamble to WHO's Constitution proclaims that "The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition". Thus, WHO's activities in regard to humanitarian emergency health assistance are directly in line with the Constitution.

88. Human rights are not limited to freedom from torture and physical oppression. Human rights also include those rights that are essential not just for human security, but also for human survival and dignity. These include the fundamental right to a standard of living that is adequate for health and well-being, including food, clothing, housing, medical care and necessary social services. Thus, WHO not only addresses the plight of refugees, but also the plight of displaced persons, returnees and the host community.

89. In line with its mandate, WHO promotes:

(a) respect for human rights amongst all groups in an equitable manner;

(b) improvement of health, education, training and environmental quality; this leads to economic development of the local community;

(c) the democratic process and the circulation of information; and

(d) links between refugees, returnees, displaced persons and the host community, and the civil society of the donor countries.

90. The operations activities carried out in the Republics of former Yugoslavia illustrate the role WHO plays in humanitarian assistance. WHO supports war-devastated populations, refugees, displaced people and the host community by:

(a) organizing international efforts to prevent deaths and unnecessary suffering;

(b) helping those affected by the conflict to maintain their good health in a hostile and hazardous environment;

(c) ensuring that local health staff have the means to reduce suffering;

(d) exercising pressure at all levels to ensure that health staff and humanitarian relief workers are free to carry out their duties under conditions of safety and protection under international humanitarian law;

(e) mobilizing emergency health relief based on objective and sound technical assessment of health needs;

(f) seeking voluntary donations for the health component of the Consolidated United Nations Programme of Action, giving priority to the needs of war-devastated populations; and

(g) ensuring that the lives and rights of dependent and disabled persons, such as those with mental illness, are respected.

91. The Charter of the United Nations itself emphasizes the role of the United Nations in promoting economic and social welfare. Article 55 commits the United Nations to promote higher standards of living, full employment and conditions of economic and social progress and development, and solution of international economic, social and health-related problems.

## 11. Equity in health care

92. In many countries, the right to health care is embodied in health legislation and in some is even a constitutional right. For many groups, however, there is frequently a large gap between the existence of this legal right and actual equity in access to health care. Dahlgren and Whitehead have described geographic, economic and cultural barriers to health care in a recent WHO discussion paper entitled "Policies and strategies to promote equity in health" (document EUR/ECP/RPD 414(2), Copenhagen, 1992). These include the difficulties in providing high-quality care in isolated, rural, mountain or island areas, and the reluctance of health personnel to serve in depressed urban areas, phenomena that exist in both the industrialized and developing countries. Systems of health care financing can restrict equity in access to health care, as can cultural barriers when the professional-patient contact is inappropriate, or migrants and guest workers are faced with language barriers. A low level of education can be an important deterrent to the demand for health care and particularly for preventive services. Those most in need of care are often least likely to receive a high standard of care, a phenomenon which has been termed by J.T. Hart the "inverse care law" (in Lancet, 1, 1971). The above-mentioned paper suggests some ways of dealing with these issues.

93. In various European countries, such as Norway, Sweden and the United Kingdom, resource allocation formulae have been used to take account of differential needs for care in different parts of the country. In Finland, the strategic planning system has been used with considerable success to

ensure the provision of high-quality services in rural areas and some health regions in England have been innovative in adapting the provision of care to meet the needs of ethnic minorities.

94. Poor economic growth has led to calls for cost containment in the provision of health care in many countries. Direct user charges are being increasingly introduced. Many of these changes harbour real dangers for equity in access to health care, as do some of the major changes in the financing of health care now being contemplated in Eastern Europe.

95. The increasing demand for high-technology care can be only too attractive to politicians due to its high visibility. This demand, if met, can have the effect of providing access to care for the few, whilst restricting access to basic services for the many.

96. Unfortunately, the possible impact of many of the changes in health care financing, of measures for cost constraint and of the balance between high technology and basic care, on equity in access to health care, is frequently not explicitly discussed. These issues merit much greater attention from researchers and decision makers.

97. The criteria for deciding on the content of the "minimum essential care basket" needs to be more explicitly defined. Restrictions of access to health care through lengthening waiting lists, etc. must be an explicit part of the political agenda, rather than the implicit rationing which presently occurs. The expected continuation of poor economic growth for some time to come, and the further restriction of resources for the health sector, makes this explicit definition of criteria essential.

98. In a recent report issued in 1992 by the Netherlands Ministry of Welfare, Health and Cultural Affairs, entitled Choices in Health Care, it is suggested that, in transferring existing types of care to the "package" covered by basic health insurance, a series of four criteria should be applied, viz.: (a) Is it necessary care, from the community point of view? (b) Has it been demonstrated to be effective? (c) Is it efficient? and (d) Can it be left to individual responsibility? It is of course possible to agree or disagree with these criteria, but the important point is that they are openly debated and discussed.

99. Organizations in the United Nations system, such as WHO, ILO and UNICEF, as well as the World Bank and other intergovernmental organizations such as the Commission of the European Communities and the OECD, all of which are involved in providing support to countries to develop their health care systems, need to work together to develop guidelines to assist countries in conducting a transparent political discussion of these important issues.

---

UNITED
NATIONS

A

General Assembly

Distr.
GENERAL

A/CONF.157/PC/61/Add.9
2 March 1993

Original: ENGLISH

WORLD CONFERENCE ON HUMAN RIGHTS
Preparatory Committee
Fourth session
Geneva, 19-30 April 1993
Item 5 of the provisional agenda

# STATUS OF PREPARATION OF PUBLICATIONS, STUDIES AND DOCUMENTS FOR THE WORLD CONFERENCE

## Addendum

## Contribution from the United Nations Population Fund

This report addresses UNFPA's work in the promotion of human rights in the area of population and development, particularly with respect to the human rights aspects of family planning.

GE. 93-11320

**UNFPA AND HUMAN RIGHTS ISSUES**

## I. INTRODUCTION

1. Since it became operational in 1969, the United Nations Population Fund (UNFPA) has worked with governments assisting them to formulate and implement population policies and programmes consonant with the principles laid down in the Universal Declaration of Human Rights. The mandate of the Fund, as specified in ECOSOC Resolution 1763, encompasses, inter alia, promoting awareness, both in developed and developing countries, of the social, economic and environmental implications of national and international population problems, of the human rights aspects of family planning and assisting countries in delineating strategies to deal with these issues in accordance with their respective plans and priorities. In carrying out its mandate, UNFPA has adhered to the fundamental principles of universality, neutrality, and respect for the sovereignty of each country.

2. This report, prepared in connexion with the upcoming World Conference on Human Rights, will present an overview of the work of UNFPA in the context of the promotion of human rights, examine the human rights dimension of selected areas of the Fund's mandate -- family planning and the status of women -- and identify some of the key issues that need to be addressed in responding to the population and development challenges of the coming decades. The annex to this report contains excerpts from various international instruments which pertain to population and human rights.

## II. UNFPA AND HUMAN RIGHTS

3. In pursuing its mandate to enable countries to respond to population and development concerns, UNFPA has been keenly aware of the universality and indivisibility of human rights. It has subscribed to the notion that all human rights are inextricably bound together and that the full enjoyment of any one human right is contingent on the realization of all the others. When the Fund launched its activities in 1969, there was at best a limited understanding of the interrelationship between population trends and the achievement of development goals and one of its first tasks was to create an awareness of these linkages. In creating this awareness, the Fund drew on the relevant articles of the Universal Declaration of Human Rights, in particular: the recognition of all individuals as persons before the law; the right to marry and to found a family; the right to work and receive equal pay for equal work; and, the right to education, social security and an adequate standard of living. Particularly important for the work of the Fund is Article 16 of the Proclamation of Teheran (1968), which underscored reproductive choice as a basic human right, stating "Parents have a basic human right to determine freely and responsibly the number and spacing of their

children." This provision has been amplified in a number of international instruments since 1968.

4. The Fund has always defined "population" in the broadest sense, addressing not only the principal demographic variables -- fertility, mortality and migration -- but also emphasizing overarching concerns such as improving the status of women, addressing special needs of adolescents and responding to the interaction between population, resources, environment and development. In implementing its mandate, UNFPA has worked in an innovative and flexible manner. From the beginning, it entered into dialogue with non-governmental organizations (NGOs) and the academic community to seek out ideas for programming in this relatively new sector. Indeed, it was one of the first United Nations organizations to use NGOs in project execution. In working with Governments, the Fund has always adhered to the principle that every nation has the sovereign right to determine its own population policy.

5. The principal areas for UNFPA assistance include the following: data collection and analysis; policy development and population research; maternal and child health and family planning; information, education and communication; and, women, population and development. In each of these substantive areas, UNFPA provides support for training, research, technical backstopping and dissemination of information. In response to Governments' requests for assistance, UNFPA, initially through such modalities as "Needs Assessments", and now through "Programme Review and Strategy Development" exercises, works with countries to articulate appropriate policies and programmes designed to build country level capacity to respond to critical concerns related to population and sustainable development. In view of limited financial resources and in response to equity considerations, UNFPA established a priority system in order that the greatest share of its resources would be allocated to those countries having the most serious population problems and in greatest need of external assistance. To qualify, countries must have a per capita income below $750 and must meet two of the following criteria: annual population increment of 100,000 or more; a gross reproduction rate of 2 or more; infant mortality rate of 120 or higher; female literacy rate of 40 per cent or below; and, agricultural population density of 2 or more persons per hectare. At present there are 56 priority countries: 31 in sub-Saharan Africa, 16 in Asia and the Pacific, 6 in the Arab States and 3 in Latin America and the Caribbean.

6. As part of its advocacy and awareness creating efforts, UNFPA has encouraged countries to recognize that population is a programmable sector and that population concerns constitute an integral part of development planning. If development planning is to respond to the essential needs of people and to enable them to exercise the basic human right to development, it is necessary to have accurate and timely data as the basis for formulating responsive policies and programmes. Hence, UNFPA has extended extensive assistance to countries to strengthen their capacity for collecting, analyzing and utilizing population data. This effort to strengthen basic population data was particularly notable in Africa, where many countries had never had a modern census and thus, had

little or no information on the size, structure and growth trends of their populations. In co-operation with the United Nations and the Economic Commission for Africa, the Fund supported the African Census Programme, which covered 22 countries and lasted from 1970 to 1977.

7. UNFPA's support for censuses and surveys and for the establishment of population planning units has made it possible for developing countries to gain a better knowledge of their demographic situations. Such knowledge is an essential first step if countries are to devise policies geared to developing human resources and to extending the right to development to its people. UNFPA has always emphasized the importance of population policies and of including population in development planning. It has stressed that policies addressing population concerns, particularly issues related to growth and distribution, are essential for social and economic development and the realization of human rights and fundamental freedoms. The increasing number of requests from countries for assistance with policy formulation and population planning prompted UNFPA to initiate the Global Programme of Training in Population and Development. This programme is intended for mid career government officials wishing to increase their knowledge of population and development interrelationships and their skills in incorporating population concerns into development planning. While all UNFPA-assisted activities can be construed as ultimately promoting human rights, the two areas where this connexion is most explicit are: family planning and reproductive rights; and, women, population and development concerns. These will be examined in the following section.

## III. THE HUMAN RIGHTS ASPECTS OF FAMILY PLANNING AND THE STATUS OF WOMEN

### Family Planning

8. Reproductive freedom as a basic human right and the right of individuals and couples to decide freely and responsibly the number and spacing of their children has been affirmed in a number of international instruments. The principle was put forth in 1966 by the UN General Assembly in Resolution 21/2211 on Population Growth and Economic Development, which stated that, "The size of the family should be the free choice of each individual family." This resolution recalled General Assembly Resolution 1838 of 18 December 1962 on population growth and economic development, and ECOSOC Resolutions 933 C (1963), 1048 (1964) and 1084 (1965) on the intensification of demographic studies, research and training on population growth and economic and social development, and on work programmes and priorities in the field of population, as well as relevant resolutions passed by the governing bodies of WHO and UNESCO. In 1968, the Teheran Conference on Human Rights re-affirmed these principles, stating

that "The protection of the family and of the child remains the concern of the international community. Parents have a basic human right to determine freely and responsibly the number and spacing of their children." (Proclamation of Teheran, Article 16.)

9. In subsequent years, these principles have been elaborated in several intergovernmental conferences and instruments. (See selected citations in Annex.) The World Population Plan of Action (WPPA) issued by the World Population Conference (Bucharest, 1974) expanded on the wording found in the Teheran Declaration by citing "individuals" and "couples". Paragraph 14f of the WPPA states, "All couples and individuals have the basic right to decide freely and responsibly the number and spacing of their children and to have the information and means to do so; the responsibility of couples and individuals in the exercise of this right takes into account the needs of their living and future children, and their responsibilities toward the community."

10. The WPPA addressed the human rights dimension of population and development issues from the micro and macro perspective. It acknowledged Governments' responsibility to provide people with the means to make effective decisions on family size. It called attention to the need for Government interventions to improve health standards, education, employment opportunities and the status of women, underscoring that these factors have considerable effects on decisions on such questions as family size and on migration. In circumstances where these responsibilities are neglected or cannot be fulfilled, the result is damaging both to individual lives and to prospects for balanced development. The WPPA notes that, "Individual reproductive behavior and the needs and aspirations of society should be reconciled. In many developing countries, and particularly in the large countries of Asia, the desire of couples to achieve large families is believed to result in excessive national population growth rates and Governments are explicitly attempting to reduce those rates by implementing specific policy measures. On the other hand, some countries are attempting to increase desired family size, if only slightly." (Para. 7).

11. The right to reproductive choice is reiterated in the recommendations of the 1984 International Conference on Population (Mexico City), in the 1979 Convention for the Elimination of All Forms of Discrimination Against Women, in the Nairobi Forward-Looking Strategy, which was agreed to at the Third World Conference on Women (Nairobi, 1985) and in the Amsterdam Declaration, which was issued by the International Forum on Population in the Twenty-First Century (Amsterdam, 1989).

12. UNFPA's mandate has placed it in a key position to enhance the possibility for people to exercise their right of reproductive choice. Over the past twenty-three years, UNFPA has worked with Governments, helping them to design family planning programmes that are financially feasible and appropriate to the cultural setting. In extending assistance, UNFPA supports all methods of family planning, including natural family planning, that are considered technically safe and effective by WHO and that are

in accordance with the policies of requesting countries. The Fund has encouraged Governments to ensure that sufficient and reliable information and counselling are available in order that family planning decisions can be made with free and informed consent. Indeed, over the years, UNFPA has devoted considerable resources to communications efforts designed to broaden knowledge regarding reproductive choice and contraceptive methods. In view of the high rates of adolescent fertility worldwide, the Fund has supported WHO in undertaking programme-related research and training activities addressing key issues in adolescent reproductive health, particularly the design of information and service programmes responsive to the needs of young women and men. Recognizing that adolescents are a particularly vulnerable group with respect to the right of reproductive choice, UNFPA, WHO and Unicef have issued a joint statement on The Reproductive Health of Adolescents (1989).

13. The experience of the Fund has underscored the importance of access to a broad range of safe and effective contraception and the availability of quality services. Thus, in extending technical assistance for family planning, the Fund has underscored to governments the need to offer a choice of contraceptive methods as well as the need to provide responsive, qualified and supportive services. UNFPA has expended approximately $46 million for basic contraceptive research and development, providing assistance to the WHO Special Programme of Research, Development and Research Training in Human Reproduction (HRP) and the International Committee on Contraception Research. In supporting such efforts, the Fund has stressed the need to develop male contraceptives, thus underscoring that family planning decisions and contraception should be a shared responsibility. The Fund has also emphasized the importance of adapting and improving already existing methods, particularly barrier methods. Such methods are especially critical in view of the AIDS pandemic and as a means of inhibiting the spread of sexually transmitted diseases.

14. The provision of "quality services" is an essential step if the human rights aspect of reproductive health and family planning is to be observed. The concept of "quality of care" is grounded in respect for the dignity of the individual and encompasses the following elements: a broad choice of contraceptive methods; provision of information to clients; technical competence of service providers; positive provider-client interaction; mechanism for client follow-up; and, an appropriate constellation of related health, medical and counselling services.

15. In order to improve the quality aspect of reproductive health care, UNFPA provides technical assistance to MCH/FP training programmes for various levels of health personnel. UNFPA support to the newly established regional training centre in Tunisia for Francophone countries has been used to strengthen its instructional programme and to develop management programmes. UNFPA provided similar assistance to the Regional Training Centre for Family Health in Mauritius. In sub-Saharan Africa, UNFPA has in recent years allocated nearly half of its assistance to MCH/FP activities in the region to training programmes. At the country level in Africa,

as part of the Fund's support to national MCH/FP programmes, rural health workers, traditional birth attendants and nurse/midwives received training in family planning techniques as well as in family planning communication.

Status of Women

16. UNFPA involvement in the area of women, population and development has been a hallmark of the organization since its inception. Cognizant of the empirical research indicating that improvements in women's status, particularly in education and health, had a beneficial impact on demographic variables, the Fund encouraged Governments to address this dimension in their population and development planning. In 1975, UNFPA issued guidelines for incorporating women's concerns into population and development activities, making it one of the first United Nations organizations to take such an initiative. These guidelines have been revised over the years to permit the Fund to respond to changing circumstances. In 1987, UNFPA's Governing Council approved a strategy for women, population and development. The objective was "the complete and total integration of women's concerns into all population activities and the increased participation of women in all projects supported by the Fund." In 1991, UNFPA's Governing Council recommended the continuation of the components of the strategy which places particular emphasis on WPD training and the strengthening of women's organizations at the local level.

17. Within the framework established by the Guidelines and Strategy, UNFPA has emphasized two basic approaches to incorporating women's concerns into its programme of work: women-specific projects; and, the integration of women into projects in all activities it supports -- this latter approach is often referred to as "mainstreaming". Women-specific projects concentrate on activities that have a direct bearing on improving the situation of women (such as education, training, skill development or economic activities) or activities aimed at increasing the awareness of policy-makers, the media and the public of the importance of women's issues. Ideally, women would staff and manage such project activities, and regional, national or local women's organizations would play a central role in these projects. Projects that are designed specifically to benefit women offer a realistic starting-point for developing more comprehensive programmes and projects. They have high rates of return in improving the situation of the family as a whole and the motivation of women to adopt family planning services. These projects offer many opportunities for women to acquire self-esteem, skills and stature in their communities. The "mainstreaming approach" is an acknowledgement that women, women's concerns and women's capabilities must have an impact on the design, implementation and evaluation of projects in all sectors, just as projects in all sectors must have an impact on women, women's concerns and women's capabilities.

18. In addition to responding to women's concerns in its programming, UNFPA takes an active advocacy role, calling attention to the disparity of opportunities between women and men at all stages of their lives and the need to redress this imbalance. The Fund maintains that if women are to realize their full potential in their productive and community roles, they must be guaranteed their reproductive rights and must be able to manage their reproductive role. This means that they must have access to reliable information, to quality family planning services, and to the health care services necessary for the prevention and treatment of debilitating infections. These are essential if women's reproductive rights are to be secured. The ability to decide freely and in an informed manner the number and spacing of one's children is the first step in enabling women to exercise other choices. When a woman realizes that she can make decisions regarding her reproductive function, this experience of autonomy spreads to other aspects of her life. It enables her to pursue diverse opportunities and empowers her to make pivotal decisions in her own life.

19. Family planning is an essential means of enhancing women's autonomy. In addition, family planning is an important health measure whose benefits have been extensively documented. Each year, 500,000 women die from complications related to pregnancy and childbirth. Ninety-nine per cent of these women live in developing countries, where the lifetime risk of maternal death is 50 to 100 times greater than in developed countries. Many of the women who do survive, suffer serious and often permanent impairment as the result of complications incurred during pregnancy and childbirth. Reproductive choice has been recognized by the international community to be a human right of critical importance to women, because the ability to carry out their multiple roles in the family, the work place and the community, hinges on good health care, nutrition and reproductive well-being. Access to contraceptive education and services combined with wider access to education and quality health care enables women to exercise both their right to reproductive choice and their right to health.

20. The central position of women in population policies and in development in general is underscored in General Assembly Resolution 45/216 of 21 December 1990. The Resolution underscores "the crucial importance of resource investments in health and education, especially for women, for the success of population programmes, and urges Governments of developing countries to strengthen, according to their economic and social capacities and conditions, their political and financial commitments to investments in the social sector, and also urges Governments of developed countries, as well as concerned international, regional and non-governmental organizations, to strengthen their financial and technical support, in the areas of health and education, to respond positively to requests for population assistance and to increase significantly the proportion of their assistance destined for population activities." (Para. 5b)

21. Because women's status affects and is affected by such demographic variables as fertility and maternal and infant mortality, reproductive choice is of vital importance to them. This special importance is affirmed in the 1979 Convention for the Elimination

of All Forms of Discrimination Against Women, the 1984 international Conference on Population held in Mexico City and the 1985 Nairobi World Conference to Review and Appraise the Achievements of the United Nations Decade for Women.

22. The 1979 Convention emphasizes the inalienable rights of women, on an equal basis with men, "to decide freely and responsibly on the number and spacing of their children and to have access to the information, education and means to exercise these rights." (Article 16e)

23. The 1984 International Conference on Population elaborated on this right, stating, "The ability of women to control their own fertility forms an important basis for the enjoyment of other rights; likewise, the assurance of socio-economic opportunities on an equal basis with men and the provision of the necessary services and facilities enable women to take greater responsibility for their reproductive lives." (Para. 17). Recommendation 18f states that efforts to reduce maternal morbidity and mortality should "support family planning as a health measure in maternal and child health programmes as a way of reducing births that occur too early or too late in the mother's life, of increasing the interval between births and of diminishing higher birth orders, and by giving special consideration to the needs of those in the post-partum and/or breast-feeding period."

24. The Amsterdam Declaration of 1989 emphasizes the imperative need to: "Recognize that women are at the centre of the development process and that the improvement of their status and the extent to which they are free to make decisions affecting their lives and that of their families will be crucial in determining future population growth rates." (Para. 1.1)

25. Consonant with the emphasis in these international instruments, many UNFPA-supported projects seek to improve the situation of women through education, training, skill development and economic activities. The Fund supports a number of projects in all regions based on the Safe Motherhood Initiative, which focuses on the needs of women, particularly the girl child and young women, and on the provision of quality mother-child health and family planning services. One of the most acute needs in the area of women and development is for gender-specific data. The Fund works closely with the United Nations Statistical Office in disseminating data on women and development. UNFPA has also funded several efforts with the Statistical Office to ensure that in all national data-collection activities, information is collected on a gender-specific basis.

26. In several countries, the Fund has supported micro-enterprises for women. For example, in the Philippines, UNFPA has funded an innovative income-generating activity which seeks to improve the lot of disadvantaged women in small fishing communities in Capiz and Pangasinan by expanding their access to credit and social services. In China, UNFPA has extended assistance, utilizing the concept of revolving funds, to women's

groups in several of the poorest counties to enable them to pursue income producing activities.

## IV. ISSUES FOR THE 1990S

27. World population as of mid-1992 stood at approximately 5.5 billion persons and it is estimated that it will reach 6 billion by 1998. Over the next decade, the annual increment will average about 97 million, the highest level ever. Almost all of this growth, 95 per cent, will take place in developing countries of Africa, Asia and Latin America. Approximately 83 per cent of the population growth during the next decade will occur in cities. This growth will result both from natural increase and from increasing flows of population from rural areas. At present there are 11 cities with more than 10 million inhabitants; seven of these are in developing countries. By the year 2000, there will be 21 cities with populations in excess of 10 million and 17 of these will be in developing countries.

28. If the present social, economic and demographic situation is indicative, there is likely to be considerable international movement of population. It is estimated that approximately 70 million people, mostly from developing countries, are working, legally or illegally, in countries other than their countries of origin. Each year over one million people permanently emigrate and close to that number seek asylum. The period from the mid 1970s to 1990 witnessed rapid growth in the number of refugees -- from 2.8 million in 1976 to 17.3 million in 1990.

29. These trends clearly indicate that population is one of the compelling issues for the coming decades. Population factors of themselves -- growth, distribution, structure and migration -- are cause for considerable concern; however, the gravity of these trends becomes even more serious when population is viewed in terms of their linkage with poverty, environmental stress, the development of human resources and the potential for all peoples to exercise their human rights.

30. As we consider critical issues in population and human rights policy for the coming years, certainly poverty reduction, preservation of the environment and improvement in the situation of women are priority areas for concern and action. Poverty reduction is one of the principal goals of all countries. A recent United Nations survey of the world social situation shows that while the per cent of people living poverty in developing countries fell from 52 per cent in 1970 to 44 per cent in 1985, the actual number living in absolute poverty increased from 944 million to 1.2 billion over the period. Poverty and population problems are closely linked. The highest rates of mortality, as well as population growth, are in poor countries and among poor people. If poverty reduction programmes are to be effective, they must address the issue of

population growth and provide improved access to quality family planning and health services and to education.

31. The United Nations Conference on Environment and Development (UNCED) highlighted the interrelationship between population and the environment. UNCED underscored that high rates of population growth and imbalances in population distribution often result in environmental degradation that constrict access to the natural resources necessary to maintain a basic standard of living. Environmental stress and the reduction of available natural resources translates into deprivation, particularly for those groups already living at the margin. The intensified focus on the environment has brought to the fore a number of equity issues, particularly with respect to consumption patterns between North and South, that will have to be addressed in the coming years.

32. International migration patterns as well as refugee movements are critical issues that the world community will have to address. It is essential that the dignity and human rights of those involved in such movements be guaranteed and observed. A first step in leading to a more informed dialogue on these issues would be to gather information on the magnitude and demographic characteristics of such flows.

33. Although the equality between women and men is proclaimed in the Universal Declaration of Human Rights and reiterated in numerous other international and national instruments, much remains to be done in order to improve the situation of women. It is now widely acknowledged that sustainable development cannot be achieved without the full participation of both women and men in all aspects of productive and reproductive life. Thus, Governments should ensure that gender specific data are collected and analyzed so that development strategies and policies can be assessed in terms of their impact on women. Such an analysis would lead to policies, strategies and programmes that are more gender-balanced.

34. Women's right to choice with respect to major decisions in their lives must be respected and facilitated. In order for this to occur, their rights before the law must be recognized and enforced and their access to education, to the resources of the household, to quality health care, to employment and to credit must be greatly expanded. In view of high levels of maternal mortality in many countries and patterns of female morbidity, governments should give priority to the adoption of measures to promote the health and nutrition of women and young girls. A key intervention in this regard would be the implementation of the Safe Motherhood Initiative. Reproductive freedom is key to the advancement of women. They must have access to information and to a range of safe and affordable contraceptive methods.

35. The results of several recent health and fertility surveys indicate a high demand for family planning. At present there is an urgent need for the development of safe and improved contraceptives for fertility regulation and for effective pharmaceutical products for protection against sexually transmitted diseases. Given the range of methods now

available, emphasis should be given to the development of male methods. In the process of contraceptive research, development and introduction, it is essential that such processes are conducted with full respect for human rights. Contraceptive research and trials of new methods should be governed by accepted ethical principles and internationally recognized standards. In particular, new methods should be tested on a range of individuals in developed and developing countries who have full information and have freely agreed to participate in the testing.

36. The experience of UNFPA during the past twenty-three years has convincingly demonstrated the importance of addressing the moral and ethical dimensions of population and development issues. It has illustrated the need to focus on reproductive rights as basic human rights and on the need to implement development policies and programmes that are equitable and appropriate and that acknowledge the centrality of women as participants in the development process. Although considerable progress has been made, much remains to be done. The Fund is committed to working with Governments, the international donor community and non-governmental organizations to ensure that population policies and programmes are responsive to national and local circumstances and that the basic human right to development is promoted and extended to all.

Annex

EXCERPTS PERTAINING TO POPULATION AND HUMAN RIGHTS FROM VARIOUS INTERNATIONAL INSTRUMENTS

## *UN GENERAL ASSEMBLY RESOLUTION: 1838 (XVII). POPULATION GROWTH AND ECONOMIC DEVELOPMENT OF 18 DECEMBER 1962*

*The General Assembly,*

*Considering* that rapid economic and social progress in the developing countries is dependent not least upon the ability of these countries to provide their peoples with education, a fair standard of living and the possibility for productive work,

*Considering* further that economic development and population growth are closely interrelated,

*Recognizing* that the health and welfare of the family are of paramount importance, not only for obvious humanitarian reasons, but also with regard to economic development and social progress, and that the health and welfare of the family require special attention in areas with a relatively high rate of population growth, ...

4. *Recommends* that the Economic and Social Council, in co-operation with the specialized agencies, the regional economic commissions and the Population Commission, and taking into account the results of the inquiry referred to in paragraph 3 (above), should intensify its studies and research on the interrelationships of population growth and economic and social development, with particular reference to the needs of the developing countries for investment in health and educational facilities within the framework of their general development programmes, ...

## *SELECTED ARTICLES FROM THE CONVENTION TO ELIMINATE ALL FORMS OF DISCRIMINATION AGAINST WOMEN, 1979*

Article 12

1. States Parties shall take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services, including those related to family planning.

2. Notwithstanding the provisions of paragraph 1 of this article, States Parties shall ensure to women appropriate services in connection with pregnancy, confinement and the post-natal period, granting free services where necessary, as well as adequate nutrition during pregnancy and lactation.

Article 16

1. States Parties shall take all appropriate measures to eliminate discrimination against women in all matters relating to marriage and family relations and in particular shall ensure, on a basis of equality of men and women: ....

e. The same rights to decide freely and responsibly on the number and spacing of their children and to have access to the information, education and means to enable them to exercise these rights.

## *SELECTED RECOMMENDATIONS FROM THE INTERNATIONAL CONFERENCE ON POPULATION, MEXICO 1984*

### Recommendations Addressing Women, Population and Development Issues

Recommendation 5

Governments are strongly urged to integrate women fully into all phases of the development process, including planning, policy and decision-making. Governments should pursue more aggressively action programmes aimed at improving and protecting the legal rights and status of women through efforts to identify and to remove institutional and cultural barriers to women's education, training, employment and access to health care. In addition, Governments should provide remedial measures, including mass education programmes, to assist women in attaining equality with men in the social, political and economic life of their countries. The promotion of community support and the collaboration, at the request of Governments, or non-governmental organizations, particularly women's organizations, in expediting these efforts should be given paramount importance.

Recommendation 6

Governments should ensure that women are free to participate in the labour force and are neither restricted from, nor forced to participate in, the labour force for reasons of demographic policy or cultural tradition. Further, the biological role and women in the reproductive process should in no way be used as a reason for limiting women's right to work. Governments should take the initiative in removing any existing barriers to the realization of that right and should create opportunities and conditions such that activities outside the home can be combined with child-rearing and household activities.

Recommendation 10

All Governments which have not already done so are strongly urged to sign and ratify or accede to the Convention on the Elimination of All Forms of Discrimination against Women.

### Recommendations Addressing Population Policies

Recommendation 33

Governments that have adopted to intend to adopt fertility policies are urged to set their own quantitative targets in this area. Countries implementing family planning programmes should establish programme targets at the operational level, respecting the basic right of couples

and individuals to decide freely and responsibly the number and spacing of their children, taking into account the needs of their living and future children and their responsibilities, assumed freely and without coercion, towards the community.

General guidelines for formulating international migration policies.

The guidelines set out below give due consideration to the basic fact that international migration is of concern to both the receiving countries and the countries of origin, particularly when the migration of skilled persons is involved. They reflect the bearing that international migration may have on the process of establishing a New International Economic Order and recognize that the effective safeguarding of the basic human rights and fundamental freedoms of all migrants, without discrimination on the basis of race, culture, religion or sex, is an essential prerequisite for the realization of their positive contributions to the host society.

Recommendation 45

International migration policies should respect the basic human rights and fundamental freedoms of individuals as set out in the Universal Declaration of Human Rights, the International Covenant on Economic, Social and Cultural Right, the International Covenant on Civil and Political Rights and other pertinent international instruments. In keeping with these documents, receiving countries should adopt measures to safeguard the basic human rights of all migrants in their territory and to ensure the respect of their cultural identity. Measures should also be taken to promote the mutual adaptation of both immigrant groups and the population of the receiving country.

Recommendations 52

All measures adopted or implemented by countries of departure and of arrival to reduce the illegal entry, stay or employment of undocumented migrants (including amnesties, other regularization schemes, border controls and deportations) should respect their basic human rights.

Recommendation 53

In formulating laws and regulations to limit undocumented migration, Governments of receiving countries are invited to consider the guidelines set forth in the ILO Convention concerning Migrations in Abusive Conditions and the Promotion of Opportunity and Treatment of Migrant Workers, 1975 (No. 143), part I. To be effective, such laws and regulations should address the treatment not only of the undocumented migrants themselves but also of those persons inducing or facilitating undocumented migration.

Recommendation 54

States that have not already done so are invited to consider acceding to the international instruments concerning refugees, in particular to the 1951 Convention and the 1967 Protocol relating to the Status of Refugees.

Recommendation 55

Governments and international agencies are urged to find durable solutions to problems related to refugees and refugee movements and to work towards the elimination of the causes of these problems. Governments, international organization and non-governmental organizations are urged to continue to promote the protection of refugees and to provide support and assistance to first asylum countries in satisfying the basic needs of refugees. Efforts towards the creation of conditions in which voluntary repatriation may take place should be pursued and assistance should be provided in rehabilitating returnees. The basic freedoms and human rights of returnees and their families should be guaranteed and assistance should be provided in developing opportunities for a return to a normal and productive way of living. In situations where neither voluntary repatriation nor resettlement in third countries appears to be feasible, Governments, international organizations and non-governmental organizations are urged to provide support and assistance to the countries of first asylum in developing the capacity of the national economic and social infrastructure to sustain, and subject to the full approval of the host countries, to integrate refugees.

## *EXCERPT FROM THE REPORT OF THE INTERNATIONAL FORUM ON POPULATION IN THE TWENTY-FIRST CENTURY (AMSTERDAM, 1989)*

In the Preamble to the Amsterdam Declaration, participants from 79 countries expressed their concerns regarding the pressing development needs and issues of the coming decades. They acknowledged that population, resources and the environment are inextricably linked and stressed their commitment to bringing about a sustainable relationship between human numbers, resources and development.

They recognized that women are at the center of the development process and that the improvement of their status and the extent to which they are free to make decisions affecting their lives and that of their families will be crucial in determining future population growth rates.

They further acknowledged that the principal aim of social, economic and cultural development, of which population policies and programmes are integral parts, is to improve the quality of people's lives. The following goals and targets were adopted by the Amsterdam Forum on Population in the Twenty-first Century in November 1989. The attainment of population goals and objectives should rest on the following:

- Strengthening of political commitment.
- Development of national strategies and programmes.
- Acceleration and expansion of resource mobilization.
- Strengthening of the role and status of women.
- Strengthening of the quality, effectiveness and outreach of family planning and maternal and child health programmes and services in both the public and the private sectors.
- Heightening community awareness and participation at all levels in the formulation and implementation of programmes and projects based on priorities and needs expressed by the women and men involved.
- Intensification of international cooperation in the sphere of population activities, especially directed and adapted to the specific conditions, particularly socio-cultural conditions, of recipient countries.

At the very least, national population goals and objectives for the coming decade and beyond should include:

- A reduction in the average number of children born per woman commensurate with achieving, as a minimum, the medium variant population projections of the United Nations.
- A major reduction in the proportion of women and men who are not currently using reliable methods of family planning, but who want to postpone, delay or limit childbearing.
- A substantial reduction in very early marriage and in teenage pregnancy.
- An increase in contraceptive prevalence in developing countries so as to reach at least 56 per cent of women of reproductive age by the year 2000.
- A reduction of the 1980 rate of infant mortality to rates of at most 50 per 1,000 live births by the year 2000 in all countries and major sub-groups within countries.
- A reduction in maternal mortality from all causes, including illegal abortion, by at least 50 per cent by the year 2000, particularly in regions where this figure currently exceeds 100 per 100,000 births.
- An increase in the average life expectancy at birth to 62 years or more for men and women in high mortality countries by the end of the century.
- A better geographical distribution of the population within national territories in balance with the proper use of resources.